Division of Medical Services
P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437
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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: October 6, 2021

SUBJ: Arkansas Medicaid Procedure Code Linking Table Project

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

If you have any comments, please submit those comments in writing, no later than November 8, 2021.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 20-76-201, 20-77-107, and 25-10-129.

Effective January 1, 2022:

The Director of the Division of Medical Services (DMS) is removing procedure codes from the Arkansas Medicaid Provider Manuals as codes are not Rules (see Arkansas Code 25-15-202(9)(B)(iv)). The revision will also bring all components of the DMS payment policy up to date now that the new interChange system is fully implemented, replacing the Medicaid Management Information System. The revision also allows DMS to make updates in a timely manner when the national procedure codes and billing criteria change.

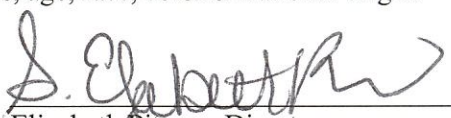
Rate codes are removed from the text of the following manuals: Adult Behavioral Health, ARKids First-B, Certified Nurse Midwife, Child Health Services/EPSDT, Children's Services Targeted Case Management, Chiropractic, Dental, Federally-Qualified Health Center, Hearing, Home Health, Hospital, Hyperalimentation, Nurse Practitioner, Outpatient Behavioral Health, Physician, Podiatrist, Portable X-Ray, Private Duty Nursing, Prosthetics, Rehabilitative Hospital, Rural Health Clinic, School-Based Mental Health, Transportation, Ventilator Equipment, and Vision. The procedure codes are being replaced with hyperlinks directing users to the Procedure Code Linking Table.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than **November 8, 2021**. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on **October 21, 2021 at 11:00 a.m**. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/85885137416. The webinar ID is 85885137416. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502035775



Elizabeth Pitman, Director
Division of Medical Services

TOC not required

218.000 Authorization for Services

~~3-1-19~~10-1-~~22~~4

All Adult Behavioral Health Services for Community Independence receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis are retrospectively reviewed for medical necessity.

~~P~~View or print the procedure codes requiring retrospective review for authorization~~:~~ and for ABHSCI services.

~~National Codes~~	~~Required Modifier~~	~~Service Title~~
~~H2023~~	~~U4~~	~~Supportive Employment~~
~~H0043~~	~~U4~~	~~Supportive Housing~~
~~H0035~~	~~U4~~	~~Partial Hospitalization~~
~~H2017~~	~~UB, U4~~	~~Adult Rehabilitative Day Service~~
~~H2017~~	~~UA, U4~~	~~Adult Rehabilitative Day Service~~
~~H2017~~	~~U3, U4~~	~~Adult Life Skills Development~~
~~H2017~~	~~U4, U5~~	~~Adult Life Skills Development~~
~~H0019~~	~~HQ, UC, U4~~	~~Therapeutic Communities – Level I~~
~~H0019~~	~~HQ, U4~~	~~Therapeutic Communities – Level 2~~

240.100 Reimbursement

~~3-1-19~~10-1-~~24~~2

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Adult Behavioral Health Services for Community Independence must be billed on a per unit basis as indicated in the service definition, as reflected in a daily total, per beneficiary, per service.

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per Adult Behavioral Health Services for Community Independence service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Adult Behavioral Health Services for Community Independence service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

15 Minute Units	Timeframe
One (1) unit =	8-24 minutes
Two (2) units =	25-39 minutes
Three (3) units =	40-49 minutes
Four (4) units =	50-60 minutes

60 minute Units	Timeframe
One (1) unit =	50-60 minutes
Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes
Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes
Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 minutes

30 Minute Units	Timeframe
One (1) unit =	25-49 minutes
Two (2) units =	50-60 minutes

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

NOTE: For services provided by a Qualified Behavioral Health Provider (QBHP), the accumulated time for the Adult Behavioral Health Services for Community Independence program service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provides Adult Life Skills Development ~~(HCPCS Code H2017, U3, U4)~~. The first QBHP spends a total of 10 minutes with the beneficiary. Later in the day, another QBHP provides Adult Life Skills Development ~~(HCPCS Code H2017, U3, U4)~~ to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance ~~(CPT Code 2019)~~ was provided, which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

View or print the procedure codes for ABHSCI services.

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.~~H0035, U4~~	Mental health partial hospitalization treatment, less than 24 hours
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.	• Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals • Rationale for continued Partial Hospitalization Services, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services • All services provided must be clearly documented in the medical record • Staff signature/credentials

NOTES	UNIT	BENEFIT LIMITS
Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual. The medical record must indicate the services provided during Partial Hospitalization.	Per Diem	DAILY MAXIMUM THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF DAYS THAT MAY BE BILLED (extension of benefits can be requested): 40

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider may not bill for any other services on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11, 49, 52, 53
EXAMPLE ACTIVITIES	
Care provided to a client who is not ill enough to need admission to facility but who has need of more	

intensive care in the therapeutic setting than can be provided in the community. This service shall include at a minimum intake, individual and group therapy, and psychosocial education. Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.

253.002 Adult Rehabilitative Day Service

~~3-1-19~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
~~H2017, UB, U4~~ QBHP Bachelors or RN ~~H2017, UA, U4~~ QBHP Non-Degreed **View or print the procedure codes for ABHSCI services.**	Psychosocial rehabilitation services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger;	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.		
NOTES	**UNIT**	**BENEFIT LIMITS**
Staff to Client Ratio – 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 6 units QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 90 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adult – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99	

253.003 Supportive Employment ~~3-1-19~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.~~H2023, U4~~	Supportive Employment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with

providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.	beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.004 Supportive Housing

~~3-1-19~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.~~H0043, U4~~	Supportive Housing

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99

253.005 Adult Life Skills Development

~~3-1-19~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
~~H2017, U3, U4~~ QBHP Bachelors or RN ~~H2017, U4, U5~~ QBHP Non-degreed **View or print the procedure codes for ABHSCI services.**	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition). Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 Minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Rehabilitative
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider –	04, 11, 12, 16, 49, 53, 57, 99

Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	

253.006 Peer Support

~~3-1-19~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for ABHSCI services.~~H0038, UC, U4~~ ~~H0038, U4 - Telephonic~~	Self-help/peer services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual contact • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	

ALLOWABLE PERFORMING PROVIDERS	PLACE OF SERVICE
• Certified Peer Support Specialist • Certified Youth Support Specialist	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99
EXAMPLE ACTIVITIES	
Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.	

253.007 Treatment Plan

~~3-1-19~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.~~90885, U4~~	~~90885:~~ Treatment Plan
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis • Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature
NOTES	**UNIT** / **BENEFIT LIMITS**

This service may be billed when the beneficiary is determined to be eligible for services. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which results in a change of Tier. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Must be reviewed annually	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72	

253.008 Aftercare Recovery Services

~~3-1-19~~10-1-~~2~~2

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
~~H2017, U4, U1~~ – QBHP Bachelors or RN ~~H2017, U4, U2~~ – QBHP Non-Degreed **View or print the procedure codes for ABHSCI services.**	Psychosocial rehabilitation services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included)

to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.	• Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature

NOTES	UNIT	BENEFIT LIMITS
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Adults – Ages 18 and Above	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	2
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

254.001 Therapeutic Communities

~~3-1-19~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
~~H0019, HQ, UC, U4 —~~Level 1 ~~H0019, HQ, U4 —~~Level 2 **View or print the procedure codes for ABHSCI services.**	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service • Document how interventions used address

<table>
<tr><td>Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.</td><td colspan="2">goals and objectives from the master treatment plan
• Information gained from contact and how it relates to master treatment plan objectives
• Impact of information received/given on the beneficiary's treatment
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Therapeutic Communities Level will be determined by the following:
• Functionality based upon the Independent Assessment Score
• Outpatient Treatment History and Response
• Medication
• Compliance with Medication/Treatment
Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment.
Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.</td><td>Per Diem</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1
YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested):
~~H0019, HQ, UC, U4 –~~ 180
~~H0019, HQ, U4 – –~~185
View or print the procedure codes for ABHSCI services.</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Adults – Ages 18 and Above</td><td colspan="2">A provider cannot bill any other services on the same date of service.</td></tr>
<tr><th></th><th colspan="2">PROGRAM SERVICE CATEGORY</th></tr>
<tr><td></td><td colspan="2">Intensive</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">N/A</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE</th></tr>
<tr><td>Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider</td><td colspan="2">14, 21, 51, 55</td></tr>
</table>

TOC not required

221.100 ARKids First-B Medical Care Benefits

~~1-1-21~~10-1-~~21~~

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code**** ~~92567~~, when the diagnosis is within the ICD range (**View ICD codes**.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	$10 per visit
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	$10 per visit
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit
Assessment	Medical Necessity	None	$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Benefit of $125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding $125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to $5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription.

****View or print the procedure codes for ARKids First-B procedures and services.

221.200 Exclusions ~~7-1-2010~~-1-224

Services Not Covered for ARKids First-B Beneficiaries:

Adult Development Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code ~~92567*~~, when the diagnosis is within the ICD range. (View ICD codes.)

Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Diapers, Underpads, and Incontinence Supplies

Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

***View or print the procedure codes for ARKids First-B procedures and services.**

222.300 Dental Services Benefit

~~8-1-15~~**10-1-22**~~1~~

Dental services benefits for ARKids First-B beneficiaries are one periodic dental exam, bite-wing x-rays, and prophylaxis/fluoride treatments every six (6) months plus one (1) day. Scalings are covered once per State Fiscal Year (SFY). Orthodontia services are also covered for ARKids First-B beneficiaries.

The **procedure codes listed in Section 262.150** may be billed for the periodic dental exams, interperiodic dental exams and prophylaxis/fluoride, and orthodontia services for ARKids First–B beneficiaries.

Refer to Section II of the Medicaid Dental Provider Manual for a complete listing of covered dental and orthodontia services. Procedures for dental treatment services that are not listed as a payable service in the Medicaid Dental Provider Manual may be requested on individual treatment plans for prior authorization review. These individually requested procedures and dental and orthodontia treatment services are subject to determination of medical necessity, review and approval by the Division of Medical Services dental consultants.

222.710 Introduction

~~4-1-09~~**10-1-22**~~1~~

The ARKids First-B Program supports preventive medicine for beneficiaries by reimbursing primary care physicians (PCPs) who provide medical preventive health screens and qualified screening providers to whom PCPs refer beneficiaries. ARKids First-B outreach efforts vigorously promote the program's emphasis on preventive medical health care. Beneficiary cost sharing does not apply to covered preventive medical health screens, including those for newborns.

The supplemental eligibility response request to an ARKids First-B beneficiary's identification card will indicate to the provider the date of the beneficiary's last preventive health screen ~~(procedure codes 99381 through 99385; and/or 99391 through 99395).~~

View or print the procedure codes for ARKids First-B procedures and services.

This information should be reviewed and verified, along with the beneficiary's eligibility, prior to performing a service. This information will assist the beneficiary's PCP or preventive health screen provider in determining the beneficiary's eligibility for the service and ensuring that preventive health screens are performed in a timely manner in compliance with the periodicity chart for ARKids First-B beneficiaries.

Newborn screens do not require PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

Nurse practitioners, in addition to newborn preventive health screens, are authorized to provide other preventive health screens with a PCP referral. **Refer to Section 262.130** for preventive health screens procedure codes.

222.750 Health Education

~~2-1-2010~~ **1-1-22**~~4~~

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive, physical examination, and the visual, hearing or dental screening provide the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. **See Section 262.130** for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

A. Counseling Visits (two (2) per SFY)~~.~~:

View or print the procedure codes for ARKids First-B procedures and services.

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
~~99406*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15-minutes)~~
~~99406*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15-minutes provided to parents of children birth through twenty (20) years of age)~~
~~99407*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)~~
~~99407*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30-minutes provided to parents of children birth through twenty (20) years of age)~~

* Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Referral of patient to an intensive tobacco cessation referral program.

C. These counseling sessions can be billed in addition to an office visit or EPSDT.

D. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Tobacco cessation sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**.

Refer to Section 257.000 and Section 292.900 of the Primary Care Physician manual for more information.

222.800 Schedule for Preventive Health Screens

~~1-1-20~~10-1-~~22~~1

The ARKids First – B periodic screening schedule follows the guidelines for the EPSDT screening schedule and is updated in accordance with the recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 18 years.

Age			
3 years	7 years	11 years	15 years
4 years	8 years	12 years	16 years
5 years	9 years	13 years	17 years
6 years	10 years	14 years	18 years

Medical screens for children are required to be performed by the beneficiary's PCP or receive a PCP referral to an authorized Medicaid screening provider. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. **See Section 262.130** for procedure codes.

224.000 Cost Sharing

1~~0~~-1-~~15~~221~~4~~

Co-payment or coinsurance applies to all ARKids First-B services, with the exception of immunizations, preventive health screenings, family planning, prenatal care, eyeglasses, medical supplies and audiological services (only Tympanometry, CPT procedure code ~~92567~~, when the diagnosis is within the ICD range (**View ICD codes**.)).

View or print the procedure codes for ARKids First-B procedures and services.

Co-payments or coinsurances range from up to $5.00 per prescription to 10% of the first day's hospital Medicaid per diem.

ARKids First-B families have an annual cumulative cost sharing maximum of 5% of their annual gross family income. The annual period is July 1 through June 30 SFY (state fiscal year). The

ARKids First-B beneficiary's annual cumulative cost sharing maximum will be recalculated and the cumulative cost sharing counter reset to zero on July 1 each year.

The cost sharing provision will require providers to check and be alert to certain details about the ARKids First-B beneficiary's cost sharing obligation for this process to work smoothly. The following is a list of guidelines for providers:

1. On the day service is delivered to the ARKids First-B beneficiary, the provider must access the eligibility verification system to determine if the ARKids First-B beneficiary has current ARKids First-B coverage and whether or not the ARKids First-B beneficiary has met the family's cumulative cost sharing maximum.
2. The provider must check the remittance advice received with the claim submitted on the ARKids First-B beneficiary, which will contain an explanation stating that the ARKids First-B beneficiary has met their cost sharing cap.
3. It is strongly urged that providers submit their claims as quickly as possible to the Arkansas Medicaid fiscal agent for payment so that the amount of the ARKids First-B beneficiary's co-payment can be posted to their cost share file and the amount added to the accrual.

240.200 Prior Authorization (PA) Process for Interperiodic Preventive Dental Screens

~~4-1-09~~10-1-~~22~~4

Prior authorization for procedure code ~~D0140~~, Interperiodic Dental Screening Exam, must be requested on the ADA claim form or online with a brief narrative through the Prior Authorization Manipulation (PAM) software. **View or print the Department of Human Services Medicaid Dental Unit Address.** Refer to your Arkansas Medicaid Dental Services Provider Manual for detailed information on obtaining prior authorizations.

View or print the procedure codes for ARKids First-B procedures and services.

Refer to Section 222.300 of this manual for coverage and Section 262.150 billing information.

262.110 Medical Supplies Procedure Codes

~~3-15-13~~10-1-~~22~~4

The following medical supplies procedure codes may be billed by Medicaid-enrolled Home Health and Prosthetics providers for ARKids First-B beneficiaries.

View or print the procedure codes for ARKids First-B procedures and services.

~~Procedure Code~~	~~Required Modifier(s)~~	~~Description~~
~~A4206~~	~~NU~~	~~Syringe with needle, sterile < or = to1cc~~
~~A4207~~	~~NU~~	~~Syringe with needle, sterile 2 cc, each~~
~~A4209~~	~~NU~~	~~Syringe with needle, sterile 5 cc or greater, each~~
~~A4216~~	~~NU~~	~~Sterile water/saline, 10 ml~~
~~A4217~~	~~NU~~	~~Sterile water/saline, 500 ml~~
~~A4221*~~	~~NU~~	~~Supplies for maintenance of drug infusion catheter per week~~
~~A4222*~~	~~NU~~	~~Supplies for external drug infusion pump per cassette or bag~~
~~A4253~~	~~NU~~	~~Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips~~
~~A4253~~	~~NU, U1~~	~~Billed for Pregnant Women services only~~
~~A4256~~	~~NU~~	~~Normal, low and high calibrator solution/chips~~

Procedure Code	Required Modifier(s)	Description
A4259 A4259	NU NU, U2	Lancets, per box Billed for Pregnant Women services only
A4265	NU	Paraffin
A4310	NU	Insertion tray without drainage bag and without catheter
A4311	NU	Insertion tray without drainage bag with indwelling catheter
A4312	NU	Insertion tray without drainage bag with indwelling catheter
A4313	NU	Insertion tray without drainage bag with indwelling catheter
A4314	NU	Insertion tray with drainage bag with indwelling catheter
A4315	NU	Insertion tray with drainage bag with indwelling catheter
A4316	NU	Insertion tray with drainage bag with indwelling catheter
A4320	NU	Irrigation tray with bulb or piston syringe, any purpose
A4322	NU	Irrigation syringe, bulb or piston
A4326	NU	Male external catheter specialty type, e.g.; inflatable,
A4327	NU	Female external urinary collection device; metal cup, each
A4328	NU	Female external urinary collection device; pouch, each
A4330	NU	Perianal fecal collection pouch with adhesive
A4331	NU	External drainage tube, any type/length, for urine leg bag/urostomy pouch, ea
A4338	NU	Indwelling catheter; foley type, two-way latex with coating
A4340	NU	Indwelling catheter; specialty type, e.g.; Coude, mushroom
A4344	NU	Indwelling catheter; foley type, two-way, all silicone
A4346	NU	Indwelling catheter; foley type, three way for continuous
A4349	NU	Male external catheter w/integral collection compartment
A4351 A4351	NU NU, U1	Intermittent urinary catheter, disposable straight tip
A4352 A4352	NU NU,U1	Intermittent urinary catheter disposable Coude (curved)
A4353 A4353	NU NU,U2	Urinary intermittent catheter with insertion supplies
A4354	NU	Insertion tray with drainage bag but without catheter
A4355	NU	Irrigation tubing set for continuous bladder irrigation
A4356	NU	External urethral clamp or compression device (not to be used for catheter clamp), each
A4357	NU	Bedside drainage bag, day or night, with or without anti reflux
A4358	NU	Urinary leg bag; vinyl, with or without tube
A4361	NU	Ostomy faceplate
A4362	NU	Skin barrier; solid, 4 x 4 or equivalent, each

Procedure Code	Required Modifier(s)	Description
A4364	NU	Adhesive for ostomy or catheter; liquid (spray, brush, etc.)
A4367	NU	Ostomy belt
A4368	NU	Ostomy filters, any type, each
A4369	NU	Ostomy skin barrier liquid spray, brush, etc.
A4371	NU	Ostomy skin barrier powder, per oz
A4394	NU	Ostomy deodorant, all types, per ounce
A4397	NU	Irrigation supply; sleeve
A4398	NU	Irrigation supply; bags
A4399	NU	Irrigation supply; cone/catheter
A4400	NU	Ostomy irrigation set
A4402	NU	Lubricant
A4404	NU	Ostomy rings
A4405	NU	Ostomy skin barrier, non-pectin based paste, per oz.
A4406	NU	Ostomy skin barrier, non-pectin based paste, per oz.
A4407	NU	Ostomy skin barrier w/flange, ext wear, w/built in convexity 4x4 or<, ea
A4414	NU	Ostomy skin barrier, w/flange (solid, flexible or accordion), w/o built in convexity, 4x4 or<, ea
A4452	NU	Tape non-waterproof per 18 sq in
A4455	NU	Adhesive remover or solvent (for tape, cement or other adhesive), per oz
A4456	NU	Adhesive remover, wipes, any type, each
A4483	NU	Moisture exchanger, disposable, for use with invasive mechanical ventilation
A4558	NU	Conductive paste or gel
A4561	NU, U1	Pessary, rubber, any type
A4562	NU	Pessary, non-rubber, any type
A4623	NU	Tracheostomy, inner cannula (replacement only)
A4624	NU	Tracheal suction catheter, any type, each
A4625	NU	Tracheostomy care or cleaning starter kit
A4626	NU	Tracheostomy cleaning brush, each
A4628	NU	Oropharyngeal suction catheter each
A4629	NU	Tracheostomy care kit for the established tracheostomy
A4772	NU	Dextrostick or glucose test stripes per box
A4927	NU	Gloves, non-sterile, per 100
A5051	NU	Pouch, closed; with barrier attached (1 piece)
A5052	NU	Pouch, closed; with barrier attached (1 piece)

Procedure Code	Required Modifier(s)	Description
A5053	NU	Pouch, closed; for use on faceplate
A5054	NU	Pouch, closed; for use on barrier with flange (2 piece)
A5055	NU	Stoma cap
A5056	NU	Ostomy pouch, drainable; with extended wear barrier attached, with filter, each (1 piece)
A5057	NU	Ostomy pouch, drainable; with extended wear barrier attached, with built-in convexity, with filter, each (1 piece)
A5061	NU	Pouch, drainable; with barrier attached (1 piece)
A5062	NU	Pouch, drainable; without barrier attached (1 piece)
A5063	NU	Pouch, drainable; for use on barrier with flange (2 piece)
A5071	NU	Pouch, urinary; with barrier attached (1 piece)
A5072	NU	Pouch, urinary; without barrier attached (1 piece)
A5073	NU	Pouch, urinary; for use on barrier with flange (2 piece)
A5081	NU	Continent device; plug for continent stoma
A5082	NU	Continent device; catheter for continent stoma
A5093	NU	Ostomy accessory; convex insert
A5102	NU	Bedside drainage bottle; rigid or expandable
A5105	NU	Urinary suspensory; with or w/o leg bag, with or without tube
A5112	NU	Urinary leg bag; latex
A5113	NU	Leg strap; latex, per set
A5114	NU	Leg strap; foam or fabric, per set
A5120	NU	Skin barrier, wipes or swabs, each
A5121	NU	Skin barrier; solid, 6 x 6 or equivalent, each
A5122	NU	Skin barrier; solid, 8 x 8 or equivalent, each
A5126	NU	Adhesive; disc or foam pad
A5131	NU	Appliance cleaner, incontinence and ostomy appliances, 16 oz
A6154	NU	Wound pouch each
A6196	NU	Alginate dressing, each (16 square inches or less)
A6197	NU	Alginate dressing, each (more than 16, but less than 48 square inches)
A6198	NU	Alginate dressing, each (more than 48 square inches)
A6203	NU	Composite dressing, each (16 square inches or less)
A6204	NU	Composite dressing, each (more than 16, but less than 48 square inches)
A6205	NU	Composite dressing, each (more than 48 square ins)
A6209	NU	Foam dressing, each (16 square inches or less)

Procedure Code	Required Modifier(s)	Description
A6211	NU	Foam dressing, wound cover pad each (more than 48 square inches)
A6212	NU	Foam dressing, wound cover pad each (16 sq in or less)
A6213	NU	Foam dressing, each (more than 16, but less than 48 square inches)
A6216	NU	Gauze non-impregnated, non-sterile, pad size 16 square inches or less) w/o adhesive border
A6219	NU	Gauze, non-impregnated pad size 16 sq in or less with adhesive border
A6220	NU	Gauze, non-impregnated pad size >16 sq in but < 48 sq in
A6221	NU	Gauze, non-impregnated, pad size > 48 sq in
A6228	NU	Gauze, impregnated, water or NS pad size 16 sq in or less
A6229	NU	Gauze, impregnated, water or NS, pad size > 16 in but < 48 sq in
A6230	NU	Gauze, impregnated, water or NS, pad size > 48 sq in
A6234	NU	Hydrocolloid dressing, each (16 square inches or less)
A6235	NU	Hydrocolloid dressing, each (more than 16, but less than 48 square inches)
A6237	NU	Hydrocolloid dressing, wound cover, pad size 16 sq in or less with adhesive
A6238	NU, U1	Hydrocolloid dressing, each (more than 48 square inches)
A6241	NU	Hydrocolloid dressing, wound cover, pad size 16 sq in or less w/o adhesive
A6242	NU	Hydrogel dressing, each (16 square inches or less)
A6243	NU	Hydrogel dressing, each (more than 16, but less than 48 square inches)
A6244	NU	Hydrogel dressing, each (more than 48 square inches)
A6245	NU	Hydrogel dressing, each (16 square inches or less)
A6246	NU	Hydrogel dressing, each (more than 16, but less than 48 square inches)
A6247	NU	Hydrogel dressing, each (more than 48 square inches)
A6248	NU	Hydrogel dressing, each (1 ounce), wound filler, gel
A6257	NU	Transparent film, each (16 square inches or less)
A6258	NU	Transparent film, each (more than 16, but less than 48 square inches)
A6259	NU	Transparent film, each (more than 48 square inches)
A6403	NU	Gauze, non-impregnated, sterile, pad size more than 16 sq in but = to or <48 sq in
A6404	NU,	Gauze, non-impregnated, sterile, pad size = to or >48 sq in

Procedure Code	Required Modifier(s)	Description
A6441	NU	Padding Bandage, non-elastic, width > or = I in & < 5 in per yd
A6442	NU	Conform bandage, non-elastic, non-sterile, width < 3 in, per yd
A6443	NU	Conform bandage, non-elastic, non-sterile, width > or = 3 in & < 5 in, per y
A6444	NU	Conform bandage, non-elastic, non-sterile, width > or = 5 in, per yd
A6445	NU	Conform bandage, non-elastic, sterile, width < 3 in, per yd
A6446	NU	Conform bandage, non-elastic, sterile, width > or = 3 in and < 5 in, per yd
A6447	NU	Conform bandage, non-elastic, sterile, width > or = 5 in, per yd
A6448	NU	Light compression bandage, elastic, width < 3 in, per yd
A6449	NU	Gauze elastic, all types, per roll (linear yard)
A6450	NU	Light compression bandage, elastic width > or = 5 in, per yd
A6451	NU	Mod compress bandage, elastic, width > or = 3 in & < 5 in, per yd
A6452	NU	High compress bandage, elastic, with > or = 3 in & < 5 in per yd
A6453	NU	Self-adherent bandage, elastic, width < 3 in, per yd
A6454	NU	Self-adherent bandage, elastic, width > or = 3 in & < 5 in, per yd
A6455	NU	Self-adherent bandage, elastic, width > or = 5 in, per yd
A6549* **	NU	Stocking, gradient compression; not otherwise specified
A7520	NU	Trach/Laryngectomy tube, non-cuffed, PVC, silicone or equal, each
A7521	NU	Trach/Laryngectomy tube, cuffed, PVC, silicone or equal, ea
A7522	NU	Trach/Laryngectomy tube, stainless steel or equal, reusable, ea
B4100**	NU	Food thickener, administered orally, per oz.
E0601*	NU, RR	**(CPAP Device Nasal Continuous Positive Airway Pressure (CPAP) Device; includes necessary accessory items) **NOTE: Complete medical data pertinent to the request must be submitted with the prior authorization request. NOTE: Bill E0601 as the global daily rental service.**
E0776	NU	IV pole

NOTE: *A4221, A4222, A6549 and E0601 must be prior authorized. Form DMS-679 must be used for the request for prior authorization. View or print form DMS-679 and instructions for completion.

**The costs ~~of B4100 and A6549~~ are not subject to the $125 medical supplies monthly benefit limit.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

262.120 Durable Medical Equipment (DME) Procedure Codes

~~11-1-17~~10-1-221

The following DME HCPCS procedure codes may be billed with appropriate modifiers by Medicaid-enrolled prosthetics providers for ARKids First-B beneficiaries.

View or print the procedure codes for ARKids First-B procedures and services.

~~HCPCS Code~~	~~Modifiers~~	~~Description~~	~~Payment Method~~
~~A4213~~	~~NU~~	~~Syringes, sterile, 20 cc or greater, each~~	~~Purchase only~~
~~A4230~~	~~NU~~	~~Infusion set for external insulin pump, non-needle cannula type~~	~~Purchase only~~
~~A4231*~~	~~NU~~	~~Infusion set for external insulin pump, needle (ea)~~	~~Purchase only~~
~~A4232*~~	~~NU~~	~~Syringe with needle for external insulin pump sterile (ea)~~	~~Purchase only~~
~~A4435~~		~~Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without (w/wo) filter, each~~	~~Purchase only~~
~~A4627~~	~~NU, UB~~	~~Spacer bag or reservoir, w/wo mask, for use with metered dose inhaler~~	~~Purchase only~~
~~A4627~~	~~NU~~	~~Spacer bag or reservoir, with mask, for use with metered inhaler~~	~~Purchase only~~
~~A4635~~	~~NU UE~~	~~Underarm pad, crutch, replacement, each~~	~~Purchase only~~
~~A4636~~	~~NU UE~~	~~Replacement, handgrip, cane, crutch or walker, each~~	~~Purchase only~~
~~A4637~~	~~NU UE~~	~~Replacement, tip, cane, crutch or walker, each~~	~~Purchase only~~
~~A4670~~	~~NU~~	~~Electronic blood pressure monitor and cuff~~	~~Rental only~~
~~A6021~~ ~~A6022~~ ~~A6023~~ ~~A6024~~	~~NU~~ ~~NU~~ ~~NU~~ ~~NU~~	~~Polyskin/Collagen dressing 16 sq in or less~~ ~~Polyskin/Collagen dressing >16 sq in but <48 sq in~~ ~~Polyskin/Collagen dressing 48 sq in or >~~ ~~Polyskin/Collagen dressing wound filler per 6 in~~	~~Purchase only~~
~~A7045~~	~~NU~~	~~Exhalation port w/wo swivel used w/accessories for positive airway device, replacement only~~	~~Purchase only~~
~~A7046~~	~~NU~~	~~Water chamber for humidifier, replacement, each~~	~~Purchase only~~

HCPCS Code	Modifiers	Description	Payment Method
A7524	NU	Tracheostoma stent/stud/button, each	Purchase only
A7525	NU	Tracheostomy mask, each	Purchase only
E0100	NU	Cane includes canes of all materials, adjustable	Purchase only
E0105	NU UE	Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips	Purchase only
E0110	NU UE	Crutches, forearm, includes crutches of various materials, complete, pair	Purchase only
E0111	NU UE	Crutch, forearm, includes crutches of various materials, complete, each	Purchase only
E0112	NU UE	Crutches, underarm, wood, adjustable or fixed, pair	Purchase only
E0113	NU UE	Crutches, underarm, wood, adjustable or fixed, each	Purchase only
E0114	NU UE	Crutches underarm, aluminum, adjustable or fixed, pair	Purchase only
E0116	NU UE	Crutch, underarm, aluminum, adjustable or fixed, each	Purchase only
E0130	NU UE	Walker, rigid adjust, or fixed height	Purchase only
E0135	NU UE	Walker, folding (pickup), adjustable or fixed height	Purchase only
E0141	NU UE	Walker, wheeled, without seat	Purchase only
E0143	NU UE	Folding walker, wheeled without seat	Purchase only
E0147	NU UE	Heavy duty, multiple breaking system, variable	Purchase only
E0153	NU UE	Platform attachment, forearm crutch, each	Purchase only
E0154	NU UE	Platform attachment, walker each	Purchase only
E0155	NU UE	Wheel attachment, rigid pickup walker, per pair	Purchase only
E0156	NU	Seat attachment, walker	Purchase only
E0157	NU UE	Crutch attachment, walker	Purchase only
E0158	NU UE	Leg extensions for a walker	Purchase only
E0159	NU	Brake attachment for wheeled walker, replacement, each	Purchase only
E0161	NU	Sitz type bath, portable, fits over commode	Purchase only

HCPCS Code	Modifiers	Description	Payment Method
	UE	seat	
E0163	NU UE	Commode chair, stationary with fixed arms	Purchase only
E0167	NU UE	Pail or pan for use with commode chair	Purchase only
E0175	NU UE	Footrest, for use with commode chair, each	Purchase only
E0181^	NU UE	Pressure pad, alternating with pump	Capped rental
E0182	NU UE	Pump for alternating pressure pad	Purchase only
E0184	NU UE	Floatation mattress, dry	Purchase only
E0185	NU UE	Decubitus care pad, floatation or gel pad with foam leveling	Purchase only
E0186*	NU	Air pressure mattress	Purchase only
E0187*	NU	Water pressure mattress	Purchase only
E0189	NU UE	Lambswool sheepskin pad, any size	Purchase only
E0190	NU UE	Decubitus care mattress	Purchase only
E0191	NU UE	Heel or elbow protector, each	Purchase only
E0196	NU	Gel pressure mattress	Purchase only
E0197	NU UE	Air pressure pad for mattress, standard mattress length and width	Purchase only
E0198*	NU	Water pressure pad for mattress, standard mattress length and width	Purchase only
E0200^	NU UE	Heat lamp, without stand (table model)	Capped rental
E0202	NU UE	Phototherapy (bilirubin) light with photometer	Rental only
E0205^	NU UE	Heat lamp, with stand, includes bulb or infrared	Capped rental
E0217^	NU UE	Water circulating heat pad with pump	Capped rental
E0225^	NU UE	Hydrocollator unit, includes pads	Capped rental
E0235	NU UE	Paraffin bath unit, portable	Purchase only
E0236^	NU UE	Pump for water circulating pad	Capped rental

HCPCS Code	Modifiers	Description	Payment Method
E0239^	NU UE	Hydrocollator unit, portable	Capped rental
E0244	NU	Raised toilet seat (manufacturer's invoice must be attached to paper claim)	Purchase only Manually priced
E0249	NU UE	Pad for water circulating heat unit	Purchase only
E0250^	NU	Hospital bed, with side rails fixed height, with mattress	Capped rental
E0255^	NU UE	Hospital bed, with side rails, variable heights, hi-lo, with mattress	Capped rental
E0260^	RR KH UE	Hospital bed, semi-electric (head and foot adjustment) with any type side rails, with mattress	Capped rental
E0271^	NU UE	Mattress, innerspring	Capped rental
E0272^	NU UE	Mattress, foam rubber	Capped rental
E0273	NU UE	Bed board	Purchase only
E0275	NU UE	Bedpan, standard, metal or plastic	Purchase only
E0276	NU UE	Bedpan, fracture, metal or plastic	Purchase only
E0280	NU UE	Bed cradle, any type	Purchase only
E0325	NU UE	Urinal; male, jug-type, any material	Purchase only
E0326	NU UE	Urinal; female jug type, any material	Purchase only
E0424^	NU	Stationary compressed gas system rental, includes contents	Rental only
E0430^	NU	Portable gaseous oxygen system, includes contents	Rental only
E0435^	NU	Oxygen system, liquid, portable, includes portable container	Rental only
E0439^	NU	Stationary liquid oxygen system rental, includes contents	Rental only
E0443	NU	Portable oxygen contents gaseous one month's supply	Purchase only
E0444	NU	Portable oxygen contents liquid one month's supply	Purchase only
E0445^	NU	Pulse oximeter (including 4 disposable	Rental only

HCPCS Code	Modifiers	Description	Payment Method
		probes)	
E0480^	NU UE	Percussor, electric or pneumatic, home model	Capped rental
E0483	UB	Replacement Pulmonary vest – vest only The manufacturer's invoice must be attached to the claim form.	Purchase only
E0483	RR	High-frequency chest wall oscillation air-pulse generator system, includes hoses and vest	Rental only
E0560	NU UE	Cascade humidification	Purchase only
E0565^	NU UE	Compressor, air power source for equipment which is not self-contained or cylinder-driven	Capped rental
E0570	NU UE	Nebulizer with compressor	Purchase only
E0575	NU UE	Ultrasonic nebulizer	Capped rental
E0585^	NU UE	Nebulizer, with compressor and heater	Capped rental
E0600	NU UE	Suction pump	Rental only
E0605	NU UE	Vaporizer room type	Purchase only
E0606^	NU UE	Postural drainage board	Capped rental
E0607	NU UE NU, U1	Home blood glucose monitor Billed for Pregnant Women services only	Purchase only
E0630^	NU UE	Patient lift, hydraulic, with seat or sling	Capped rental
E0650^	NU UE	Pneumatic compressor, non-segmental	Capped rental
E0667^	NU	Pneumatic appliance (leg)	Capped rental
E0668^	NU	Pneumatic appliance (arm)	Capped rental
E0670	EP	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	Purchase only
E0691^	NU	Ultraviolet light therapy system panel, bulbs/lamps/timer/eye protect < 2 sq. ft. treat area	Rental only
E0692^	NU	Ultraviolet light therapy panel, bulbs/lamps/timer/eye protection, 4 ft. panel	Rental only

HCPCS Code	Modifiers	Description	Payment Method
E0693^	NU	Ultraviolet light therapy system panel, bulbs/lamps/timer/eye protection, 6 ft. panel	Rental only
E0694^	NU	Ultraviolet light therapy system panel, bulbs/lamps/timer/eye protection, 6 ft. cabinet	Rental only
E0720^	NU UE	TENS, two leads, localized stimulation	Capped rental
E0730^	NU UE	TENS, four leads, larger area/multiple nerve stimulation	Capped rental
E0740	NU UE	Replacement batteries for medically necessary TENS	Purchase only
E0745^	NU UE	Neuromuscular stimulator, electronic shock unit	Capped rental
E0747^	NU UE	Osteogenesis stimulator	Rental only
E0760*	NU	Osteogenesis stimulator, low intensity ultrasound, non-invasive	Rental only
E0779 E0779^	RR	Ambulatory infusion device, payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home	Rental only
E0840	NU UE	Traction frame attached to headboard, simple cervical traction	Purchase only
E0850	NU UE	Traction stand, free standing cervical traction	Purchase only
E0860	NU	Traction equipment, over door, cervical	Purchase only
E0870	NU UE	Traction frame attached to footboard, extremity traction	Purchase only
E0880	NU UE	Traction stand, free standing, extremity, traction	Purchase only
E0890	NU UE	Traction frame, attached to footboard, pelvic traction	Purchase only
E0900	NU UE	Traction stand, free standing, pelvic traction	Purchase only
E0910^	NU UE	Trapeze bars, attached to bed, complete with grab bar	Capped rental
E0920* ^	NU UE	Fracture frame attached to bed, includes weights	Capped rental
E0930^	NU UE	Fracture frame, free standing, includes weights	Capped rental
E0935^	NU UE	Passive motion exercise device	Capped rental

HCPCS Code	Modifiers	Description	Payment Method
E0936 Bill on paper	NU	Continuous passive motion exercise device for use other than knee	Capped Rental
E0940^	NU UE	Trapeze bar, free standing, complete with grab bar	Capped rental
E0941^	NU UE	Gravity assisted traction device, any type	Capped rental
E0942	NU UE	Cervical head harness/halter	Purchase only
E0944	NU UE	Pelvic belt/harness/boot	Purchase only
E0945	NU UE	Extremity belt/harness	Purchase only
E0946	NU UE	Fracture frame, dual with cross bars, attached	Purchase only
E0947	NU UE	Fracture frame, attachments for complex pelvic	Purchase only
E0948	NU UE	Fracture frame, attachments for complex cervical	Purchase only
E1130^	NU UE	Standard wheelchair, fixed full length arms, fixed or swing away detachable footrests	Capped rental
E1140	NU	With chair detachable arms, desk or full length	Capped rental
E1150	NU	With chair detachable arms, desk or full length	Capped rental
E1160	NU	With chair, fixed full length arms, swing away	Capped rental
E1224** ^	NU UE	Footrest wheelchair with detachable arm	Capped rental
E1390^	NU	Oxygen concentrator manufacturer specified maximum flow rate	Rental only
E1391* ^	NU	O2 concentrator, dual delivery port, 85% or > O2 concentration, each	Rental only
E2601	NU	General use wheelchair seat cushion, width less than 22 in., any depth	Purchase only
E2602	NU	General use wheelchair seat cushion, width 22 in. or greater, any depth	Purchase only
E2611	NU	General use wheelchair seat cushion, width 22 in. or greater, any depth	Purchase only
E2612	NU	General use wheelchair seat cushion, width 22 in. or greater, any depth	Purchase only
E2622	NU	Skin protection wheelchair seat cushion, adjustable, width less than 22 in., any depth	Purchase only

HCPCS Code	Modifiers	Description	Payment Method
E2623	NU	Skin protection wheelchair seat cushion, adjustable, width 22 in. or greater, any depth	Purchase only
E2624	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 in., any depth	Purchase only
E2625	NU	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 in. or greater, any depth	Purchase only
K0739	NU, UI	Durable medical equipment repair labor only (a maximum of 20 units per date of service is allowed) (1 unit = 15 minutes of labor)	Labor charges only
K0739	NU	Durable medical equipment parts only. Repairs/parts will not be approved for more than the allowed purchase price of new equipment. The manufacturer's invoice for all parts must be attached to claim form.	Manually priced
K0739	NU, U4	Maintenance for capped rental items	Labor charges only
L8605		Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1 ml, includes shipping and necessary supplies	Purchase only

NOTES: Codes denoted with an asterisk * (A4231, A4232, E0186, E0187, E0198, E0760, E0920, and E1391) must be prior authorized. Form DMS-679A must be used for the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

** Code E1224 must be prior authorized through the Division of Medical Services, Utilization Review. Form DMS-679 must be used for the request for prior authorization. **View or print form DMS-679 and instructions for completion.**

Codes denoted with ^ symbol are approved for special circumstance "Initial" billing (See Section 242.111 of the Prosthetics Medicaid Provider Manual for details regarding "initial" billing). These codes must be billed WITHOUT A MODIFIER to indicate the "Initial" bill circumstance applies – EXCEPTION – if a modifier KH is specifically indicated, that modifier must be used.

262.130 Preventive Health Screening Procedure Codes

10-1-2215

There are two (2) types of full medical preventive health screening procedure codes to be used when billing for this service for ARKids First-B beneficiaries; Newborn and Child Preventive Health Screening:

1. ARKids First-B Preventive Health Screening: Newborn

   The initial ARKids First-B preventive health screen for newborns is similar to Routine Newborn Care in the Arkansas Medicaid Physician and Child Health Services (EPSDT) Programs.

For routine newborn care following a vaginal delivery or C-section, procedure code ~~99460, 99461 or 99463~~, with the required modifier UA and a primary detail diagnosis (**View ICD codes**.) must be used one time to cover all newborn care visits by the attending provider. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to code ~~99460, 99461 or 99463~~. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), and are considered to be the Initial Health Screening.

For newborn illness care, e.g., neonatal jaundice, following a vaginal delivery or C-section, use procedure codes range ~~99221 through 99223~~. Do not bill codes ~~99460, 99461 or 99463~~ (routine newborn care) in addition to the newborn illness care codes.

2. ARKids First-B Preventive Health Screening: Children

Preventive health screenings in the ARKids First-B Program are similar to EPSDT screens in the Arkansas Medicaid Child Health Services (EPSDT) Program in content and application. Billing, however, differs from Child Health Services (EPSDT). All services, including the preventive health medical screenings, are billed in the CMS-1500 claim format for both electronic and paper claims.

All preventive health screenings after the newborn screen are to be billed using the preventive health screening procedure codes ~~99381-99385 or 99391-99395~~.

Providers may bill ARKids First-B for a sick child visit in addition to a preventive health screen procedure code ~~(99381-99385 or 99391-99395)~~ for the same date of service if the screening schedule indicates a periodic screen is due to be performed.

View or print the procedure codes for ARKids First-B procedures and services.

~~Procedure Code~~	~~Required Modifier~~	~~Description~~
~~99460[1]~~	~~UA~~	~~Initial hospital/birthing center care, normal newborn (global).~~
~~99461[1]~~	~~UA~~	~~Initial care normal newborn other than hospital/birthing center (global).~~
~~99463[1]~~	~~UA~~	~~Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global).~~
~~99221[1]~~ ~~99223[1]~~		~~Initial Newborn Care For Illness Care (e.g. neonatal jaundice)~~
~~99381-99385~~		~~Comprehensive Preventive Medicine Health Evaluation/Screen (New Patient)~~
~~99391-99395~~		~~Comprehensive Preventive Medicine Health Evaluation/Screen (Established Patient)~~
~~36415[2]~~		~~Collection of venous blood by venipuncture~~
~~83655~~		~~Lead~~

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab
[3] Arkansas Medicaid description of the service

Immunizations and laboratory tests procedure codes are to be billed separately from comprehensive preventative health screens.

Billing for ARKids First-B services, including preventive health medical screenings and ARKids First-B SCHIP vaccine injection administration fees, are to be billed in the CMS-1500 claim format ONLY; for both electronic and paper claims.

262.150 Billing Procedure Codes for Periodic Dental Screens and Services and Orthodontia Services

~~8-1-15~~10-1-22~~1~~

View or print the procedure codes for ARKids First-B procedures and services.

A. Initial/Periodic Preventive Dental Screens

Periodicity schedule once each six months plus one day – must be billed with procedure code ~~D0120~~.

B. Interperiodic Preventive Dental Screens

ARKids First-B beneficiaries may receive interperiodic preventive dental screening, if required by medical necessity. There are no limits on these services; however, prior authorization must be obtained in order to receive reimbursement. Refer to Section 240.200 of this manual for dental prior authorization information.

Procedure code ~~D0140~~ must be billed for an interperiodic preventive dental screen. **This service requires prior authorization (see Section 240.200)**.

The procedure codes listed in the table below must be billed for prophylaxis/fluoride.

~~Procedure Code~~	~~Description~~
~~D1110~~	~~Prophylaxis – adult (ages 10-18)~~
~~D1120~~	~~Prophylaxis – child (ages 0-9)~~
~~D1208~~	~~Topical application of fluoride (including prophylaxis) - all ages~~
~~D1206~~	~~Topical application of fluoride varnish (ages 0-20)~~

Refer to Section 222.300 for further details regarding dental services for ARKids First–B beneficiaries.

C. Orthodontia Services

Comprehensive Orthodontic Treatment – Permanent Dentition	
~~Procedure Code~~	~~Description~~
~~D8070~~	~~Class I Malocclusion~~
~~D8080~~	~~Class II Malocclusion~~
~~D8090~~	~~Class III Malocclusion~~

Other Orthodontic Devices	
~~Procedure Code~~	~~Description~~
~~D8210~~	~~Removable appliance therapy~~

Other Orthodontic Devices	
~~Procedure Code~~	~~Description~~
~~D8220~~	~~Fixed appliance therapy~~
~~D8999~~	~~Unspecified orthodontic procedure, by report~~

Refer to Section II of the Medicaid Dental Provider Manual for service definitions, information regarding reimbursement, prior authorization and other information pertaining to orthodontic treatment.

262.400 Billing Procedures for Preventive Health Screens

~~9-1-14~~10-1-22~~1~~

ARKids First-B reimburses providers for preventive health screenings performed at the intervals recommended by the American Academy of Pediatrics.

References in this section indicate that ARKids First-B preventive health screenings are similar to Arkansas Medicaid Child Health Services (EPSDT) screens in content and application.

View or print the procedure codes for ARKids First-B procedures and services.

However, please note this important distinction:

Claims for ARKids First-B preventive health screenings electronically or by paper must be billed in the CMS-1500 claim format.

NOTE: Certified nurse-midwives are restricted to performing the preventive health screen, Newborn, only, and must bill either code ~~99460, 99461 or 99463~~, with the required UA modifier, for initial newborn screen or codes ~~99221 or 99223~~ for newborn illness care.

A Certified nurse-midwife may NOT bill procedure codes ~~99381-99385 or 99391-99395~~ for child preventive health screens.

262.410 Primary Care Physician Referral Requirements for Preventive Health Screens

~~2-1-10~~10-1-22~~1~~

All preventive health screens ~~99381-99385 or 99391-99395~~ for ARKids First-B beneficiaries must be provided by the primary care physician (PCP) of the beneficiary or by PCP referral to a qualified practitioner.

View or print the procedure codes for ARKids First-B procedures and services.

Newborn preventive health screens are exempt from the PCP referral requirement.

Immunizations for childhood diseases are exempt from the PCP referral requirement.

262.420 Limitation on Laboratory Procedures Performed During a Preventive Health Screen

~~3-15-13~~10-1-22~~1~~

ARKids First-B preventive health screens will not include laboratory procedures unless the screen is performed by the beneficiary's PCP, is conducted pursuant to a referral from the PCP or is included in the exceptions listed below.

View or print the procedure codes for ARKids First-B procedures and services.

Exceptions

The following tests are exempt from the above limitations and may continue to be billed in conjunction with a preventive health screen performed in accordance with existing Medicaid policy only if they are performed within seven (7) calendar days following the screen:

81000	81001	81002	83020	83655
85013	85014	85018	86580	95199

Claims for laboratory tests, other than those specified above, performed in conjunction with a preventive health screen will be denied unless the screen is performed by the PCP or pursuant to a referral from the PCP.

262.430 Vaccines for ARKids First-B Beneficiaries

8-1-15~~10~~-1-22~~1~~

ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information.**

Only a vaccine injection administration fee is reimbursed. When filing claims for administering vaccines for ARKids First-B beneficiaries, providers must use the CPT procedure code for the vaccine administered and the required modifier **SL only** for either electronic or paper claims. Providers must bill claims for ARKids First-B beneficiaries using the CMS-1500 claim format.

The following list contains the SCHIP vaccines available to ARKids-First-B beneficiaries through the Arkansas Department of Health.

View or print the procedure codes for ARKids First-B procedures and services.

Procedure Code	M1	Age Range
90633	SL	12 months-18 years
90634	SL	12 months-18 years
90636	SL	18 years only
90645	SL	0-18 years
90646	SL	0-18 years
90647	SL	0-18 years
90648	SL	0-18 years
90649	SL	9-18 years
90650	SL	9-18 years
90654	SL	18 years
90655	SL	6 months-35 months
90656	SL	3 years-18 years
90657	SL	6 months-35 months
90658	SL	3 years-18 years
90660	SL	2 years-18 years (not pregnant)
90669	SL	0-4 years
90670	SL	6 weeks-5 years

Procedure Code	M1	Age Range
90672	SL	2 years-18 years
90673	SL	18 years
90680	SL	6 weeks to 32 weeks
90681	SL	6 weeks to 32 weeks
90685	SL	6 months through 35 months
90686	SL	3-18 years
90688	SL	3-18 years
90696	SL	4-6 years
90698	SL	0-4 years
90700	SL	0-6 years
90702	SL	0-6 years
90707	SL	0-18 years
90710	SL	0-18 years
90713	SL	0-18 years
90714	SL	7-18 years
90715	SL	7-18 years
90716	SL	0-18 years
90720	SL	0-18 years
90721	SL	0-18 years
90723	SL	0-18 years
90732	SL	2-18 years
90734	SL	0-18 years
90743	SL	0-18 years
90744	SL	0-18 years
90747	SL	0-18 years
90748	SL	0-18 years

262.431 Billing of Multi-Use and Single-Use Vials

11-1-1510-1-221

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges 96365 through 96379.

View or print the procedure codes for ARKids First-B procedures and services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider

shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

TOC not required

242.100 Procedure Codes

~~7-1-07~~10-1-~~22~~1

The procedure codes for billing chiropractic services are below. **View or print the procedure codes for Chiropractic services.**

~~98940~~	~~98941~~	~~98942~~	~~76499*~~

*Procedure code ~~76499~~ is to be used when filing claims for chiropractic x-ray. This benefit is limited to two (2) per state fiscal year. This service counts against the $500 per beneficiary per state fiscal year laboratory and X-ray benefit limit.

242.310 Completion of the CMS-1500 Claim Form

~~5-1-18~~10-1-~~22~~1

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	

Field Name and Number		Instructions for Completion
	ZIP CODE TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	b. OTHER CLAIM ID NUMBER	Not required.
	c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: lLLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or lllness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Not required
17a. (blank)	Not required.
17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail. **Refer to Section 242.100** for procedure codes.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

213.710 Fetal Non-Stress Test

~~10-13-03~~10-1-~~22~~4

The fetal non-stress test is limited to two (2) medically necessary fetal non-stress test procedures per pregnancy. Providers must follow the benefit extension procedures in Section 214.000 to request that Medicaid authorize payment of a third or subsequent claim after two (2) claims have been paid in a nine-month period. The procedure code for a fetal non-stress test is ~~59025~~ in the link below.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

Post procedural visits are covered within the 10-day period following a fetal non-stress test.

272.412 Pudendal Nerve Block

~~10-13-03~~10-1-~~22~~4

CPT code ~~64430~~ may be billed when administering a pudendal nerve block.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.430 Family Planning Services for Beneficiaries

~~10~~-1-~~15~~221

See Sections 215.200 through 215.260 for family planning coverage information.

Laboratory procedure codes covered for family planning are listed in **Section 272.431** of this manual.

For other billable family planning services, see Sections 272.440-272.533.

272.431 Family Planning Services Laboratory Procedure Codes

~~10~~-1-~~15~~221

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

~~81000~~	~~81001~~	~~81002~~	~~81003~~	~~81025~~
~~83020~~	~~83520~~	~~84703~~	~~85014~~	~~85018~~
~~85660~~	~~86592~~	~~86593~~	~~86687~~	~~86701~~
~~87075~~	~~87081~~	~~87088~~	~~87210~~	~~87390~~
~~87470~~	~~87490~~	~~87590~~		

272.440 Billable Family Planning Services for Beneficiaries

~~5-1-17~~10-1-~~2~~42

A. Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail.** Laboratory procedure codes covered for family

planning are listed in **Section 272.431**. Other billable family planning services are also listed in **Section 272.533**.

B. The following procedure code table explains the family planning visit services payable to certified nurse-midwives.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Procedure Code	Modifier(s)	Description
99401	FP, UA, SB	Family Planning Periodic visit
99402	FP, SB	Family Planning Basic visit

C. The following procedure table explains family planning codes payable to certified nurse-midwives.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

11976*	11981*	58300*	58301*	J1050**
J7297**	J7298**	J7300**	J7301**	J7307**

* For Family Planning modifiers, FP and SB are required.

** See Section 272.533 H for additional billing information.

272.451 Specimen Collection

7-1-0510-1-22

The policy in regard to collection, handling and/or conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization.

C. Specimen collection is not reimbursable when the provider collecting the specimen also performs laboratory tests on the specimen.

The following procedure codes may be used when billing for specimen collection:

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

P9612 P9615 36415

272.452 Tobacco Cessation Counseling Services

2-1-2010-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
~~99406*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15 minutes)~~
~~99406*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15 minutes provided to parents of children birth through twenty (20) years of age)~~
~~99407*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intensive, 30 minutes)~~
~~99407*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30 minutes provided to parents of children birth through twenty (20) years of age)~~

* Exempt from PCP referral requirements.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18) and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**

272.470 Newborn Care **10-1-~~15~~221~~~~**

All newborn services must be billed under the newborn's own Medicaid identification number midwife can refer interested individuals to the Department of Human Services through the 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/certified nurse-midwife can refer interested individuals to the Department of Human Services through the Hospital/Physician/Certified Nurse-Midwife Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

For routine newborn care following a vaginal delivery or C-section, procedure code ~~**99460, 99461 or 99463**~~ should be used one time to cover all newborn care visits. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to ~~**99460, 99461 and 99463**~~. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), and are considered to be the initial Child Health Services (EPSDT) screen. Routine newborn care is exempt from the PCP requirement.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

For illness care (e.g., neonatal jaundice), use procedure codes ~~**99221 through 99223**~~. Do **not** bill ~~**99460, 99461 or 99463**~~ in addition to these codes.

For newborn resuscitation, use procedure code ~~99465~~.

~~99460, 99461, and 99463 m~~May be billed on the CMS-1500 claim form or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically for ARKids A beneficiaries. For ARKids B-beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center. **View or print the Provider Assistance Center contact information.**

For ARKids A (EPSDT) – Requires a 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)~~

For ARKids First B – Requires a 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)~~

See Sections 241.000 – 243.310 of the EPSDT manual for specific EPSDT billing instructions.

272.491 Method 1 – "Global" or "All-Inclusive" Rate

A. One charge for total obstetrical care is billed. The single charge would include the following:

1. Antepartum care, which includes:
   a. initial and subsequent history
   b. physical examinations
   c. recording of weight
   d. blood pressure
   e. fetal heart tones
   f. routine chemical urinalyses
   g. maternity counseling
   h. office visit charge when diagnosis is pregnancy related
2. Admission to the hospital. All admissions and subsequent hospital visits for the treatment of false labor.
3. Delivery - vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary.
4. Postpartum care, which includes hospital and office visits following vaginal delivery.

B. The global method must be used when the following conditions exist:

1. At least two months of antepartum care were provided culminating in delivery.
2. The patient was continuously Medicaid eligible for at least two months before delivery.

If either condition is not met, the claim will be denied. The denial will state either "monthly billing required" or "beneficiary ineligible for service dates."

C. When billing for global care, procedure code ~~59400 or 59610~~ must be used.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

The provider should indicate in the date of service field of the claim form:

1. The first date of antepartum care after Medicaid eligibility has been established
2. The date of delivery
3. If these two dates are not entered and are not at least two months apart, payment will be denied. The filing deadline will be calculated based on the date of delivery.

D. No benefits are counted against the beneficiary's annual office visit benefit limit if the global method is used.

E. The global method of billing should be used when one or more certified nurse-midwives in a group sees the patient for one or more prenatal visits. The certified nurse-midwife who delivers the baby should be listed as the attending provider on the claim for global obstetric care.

272.492 Method 2 – "Itemized Billing"

~~7-1-06~~10-1-~~22~~4

Itemized billing must be used when the following conditions exist:

A. Less than two months of antepartum care was provided.

B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.

C. If Method 2 is used to bill OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

D. If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure code ~~59409~~ should be billed for vaginal delivery. Procedure codes ~~59400 and 59410~~ may not be billed in addition to procedure code ~~59409~~. These procedures will be reviewed on a post-payment basis to ensure that they are not billed in addition to antepartum or postpartum care.

E. Providers may bill laboratory and X-ray services separately using the appropriate CPT procedure codes if this is the certified nurse-midwife's standard office practice.

1. When lab tests and/or x-rays are pregnancy related, the referring certified nurse-midwife must be sure to code appropriately when these services are sent to the lab or x-ray facility. The diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.
2. The obstetrical laboratory profile procedure code ~~80055~~ consists of four components: complete blood count, VDRL, Rubella and blood typing with RH. If the ASO titer ~~(procedure code 86060)~~ is performed, the test should be billed separately using the individual code.
3. As with any laboratory procedure, if the specimen is sent to an outside laboratory, only a collection fee may be billed. The laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 272.450 of this manual.

NOTE: Payment will not be made for emergency room certified nurse-midwife charges for an OB patient admitted directly from the emergency room into the hospital for delivery.

272.493 Obstetrical Care Without Delivery

~~7-1-06~~10-1-~~22~~4

Certified nurse-midwives must use procedure code ~~59425~~ with modifier **UA** to bill for one to three visits for antepartum care without delivery.

Procedure code ~~59425~~ with no modifier must be used by providers to bill four to six visits for antepartum care without delivery. Procedure code ~~59426~~ with no modifier is to be used for 7 or more visits without delivery.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

This enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided. Coverage for this service will include routine sugar and protein analysis. One unit equals one visit. Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the claim and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by the Arkansas Medicaid fiscal agent prior to 12 months from 1-10-05 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

272.494 Fetal Non-Stress Test, Fetal Echography (Ultrasound) and External Fetal Monitoring

10-1-~~15~~221

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. The fetal non-stress test, procedure code ~~59025~~, has a benefit limitation of two (2) per pregnancy. Prior authorization is not required.

B. CPT procedure code ~~59050~~ is applicable only to internal fetal monitoring during labor by a consultant. Procedure code ~~59050~~ with modifier **U1**, for external fetal monitoring, is payable to the certified nurse-midwife when performed in a certified nurse-midwife's office or clinic. Certified nurse-midwives may bill no more than one unit per day of external fetal monitoring, not to exceed two (2) per pregnancy.

C. Benefit limits apply to fetal echography (ultrasound), procedure codes ~~76815, 76816, 76818 and 76819~~.

D. Fetal echography is limited to two (2) per pregnancy. If it is necessary to exceed these limits, the certified nurse-midwife must request an extension of benefits. See Section 214.000 for benefit extension procedures.

272.495 Risk Management Services for Pregnancy

10-1-~~15~~221

A certified nurse-midwife may provide the risk management services listed below if he or she employs the professional staff indicated in the service descriptions below. If a certified nurse-midwife does not choose to provide the risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy. Each of the risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. Risk Assessment

A medical, nutritional and psychosocial assessment by the certified nurse-midwife or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
2. Nutritional assessment to include:
   a. 24-hour diet recall
   b. Screening for anemia
   c. Weight history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~99402~~	~~SB, U1, UA~~	~~Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an~~

Procedure Code	Modifier(s)	Description
		individual; approximately 30 minutes

B. Case Management Services

Services by a certified nurse-midwife, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services. (Examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to perform delivery following-up to verify that the patient kept appointment, rescheduling appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management service contact may be with the patient, other professionals, family and/or other caregivers.

Procedure Code	Modifier(s)	Description
Low Risk: 99402	SB, U4, UA	Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes
High Risk: 99402	SB, U5, UA	Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes

C. Perinatal Education

Educational classes provided by a health professional (Certified Nurse-Midwife, Public Health Nurse, Nutritionist or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

Procedure Code	Modifier(s)	Description
99402	SB, UA	Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual; approximately 30 minutes

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan or
2. Nutritional care plan follow-up and reassessment, as indicated.

Maximum: 9 units per pregnancy

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~99402~~	~~SB, U2, UA~~	~~Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes~~

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan or
2. Social work plan follow-up, appropriate intervention and referrals.

Maximum: 6 units per pregnancy

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~99402~~	~~SB, U3, UA~~	~~Office or other outpatient consultations, new or established; patient confirmatory consultations, new or established.~~

F. Early Discharge Home Visit

If a certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be made by certified nurse-midwife order (includes hospital discharge order).

A certified nurse-midwife may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Procedure codes: CPT procedure codes ~~**99341, 99342, 99343, 99347, 99348**~~ and ~~**99349**~~ as applicable.

272.502 Non-Emergency Services

~~7-1-06~~10-1-~~22~~1

Procedure code ~~**T1015**~~ (modifier **U3**) should be billed for a non-emergency certified nurse-midwife visit.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.533 Injections, Therapeutic and/or Diagnostic Agents

~~11-1-17~~10-1-~~22~~1

A. 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 Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code~~, T1502~~ is payable for beneficiaries of all ages. ~~**T1502**~~ ~~m~~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** c~~Cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

~~**T1502** c~~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** c~~Cannot be billed when the drug administered is not FDA approved.

See the table below when billing ~~T1502~~:

~~**Procedure Code**~~	~~**Modifier**~~	~~**Eligibility Category**~~
~~T1502~~	~~EP~~	~~ARKids A (Ages 0-20)~~
~~T1502~~	~~SL~~	~~ARKids B~~
~~T1502~~		~~Ages 19 and above~~

Most of the covered drugs can be billed electronically. **However, any covered 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 for manually priced drugs is based on a percentage of the average wholesale price.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 272.531 for further information.

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 certified nurse-midwife if performed in any other setting. Therapeutic injections should only be provided by certified nurse-midwives 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 form. 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 payable CPT code ranges ~~**96365** through **96379** and **96401** through **96549**~~ for therapeutic and chemotherapy administration procedure codes.

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
3. All other billing requirements must be met in order for payment to be approved.

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.**

Coverage criteria for all immunizations and vaccines are listed in Part F of this section.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. **Vaccines for Children (VFC)**

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

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

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the VFC Program; however vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids First-B SCHIP vaccines. **View or print the Department of Health contact information.**

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables in this section of this manual. See Part F of this section.

E. **Billing of Multi-Use and Single-Use Vials**

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

1. 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 payable CPT code ranges ~~96365 through 96379~~.
2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
    a. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
    b. **Multi-Use Vials** are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

c. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

d. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.

F. **Tables of Payable Procedure Codes**

The tables of payable procedure codes are designed with eight columns of information.

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
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(y) or months (m).
4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 240.000 for prior authorization.)

G. **Process for Obtaining a Prior Authorization (PA) 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 PA number. Instead of attaching a prior approval letter to a paper claim, providers will now list the PA number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring PA 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 PA number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding PA 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 PA must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a PA is required in a provider manual or an official Division of Medical Services correspondence.

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

A decision letter will be returned to the provider by fax or *e-mail* 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.

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.

H. **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.reviewpoint/**
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

I. All family planning procedures require an FP modifier and a primary family planning diagnosis on the claim.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 003/103 restrictions apply to ages twenty-one (21) years and above unless otherwise indicated in the age restriction column.

~~*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)~~

~~See Section 240.000-240.200 for prior authorization procedures.~~

~~List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 51 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.~~

~~Procedure Code~~	~~Modifier~~	~~Age Restriction~~	~~Diagnosis~~	~~Diagnosis List~~	~~Review~~	~~PA~~	~~Prior Approval Letter~~
~~J0290~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0360~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0461~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0500~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0520~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0558~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0561~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0610~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0670~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0690~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0694~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0695~~	~~No~~	~~18y & up~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~
~~J0696~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~
~~J0697~~	~~No~~	~~No~~	~~No~~	~~003/103~~	~~No~~	~~No~~	~~No~~

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 51 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0698	No	No	No	003/103	No	No	No
J0702	No	No	Yes	003/103	No	No	No
NOTE: Procedure code J0702 is covered for a valid diagnosis code from range (**View ICD codes.**) for complications of pregnancy or List 003 for all ages.							
J0710	No	No	No	003/103	No	No	No
J0970	No	No	No	003/103	No	No	No
J1000	No	No	No	003/103	No	No	No
J1050	FP	10y & up	No	No	No	No	No
J1100	No	No	Yes	003/103	No	No	No
NOTE: Procedure code J1100 is covered for a valid diagnosis code from range (**View ICD codes.**) for complications of pregnancy or List 003 for all ages.							
J1200	No	No	No	003/103	No	No	No
J1240	No	No	No	003/103	No	No	No
J1320	No	No	No	003/103	No	No	No
J1330	No	No	No	003/103	No	No	No
J1380	No	No	No	003/103	No	No	No
J1410	No	No	No	003/103	No	No	No
J1435	No	No	No	003/103	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 51 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1580	No	No	No	003/103	No	No	No
J1626	No	No	No	003/103	No	No	No
J1670	No	No	No	003/103	No	No	No
J1750	No	No	No	No	No	No	No
J1815	No	No	No	003/103	No	No	No
J1840	No	No	No	003/103	No	No	No
J1850	No	No	No	003/103	No	No	No
J1890	No	No	No	003/103	No	No	No
J1940	No	No	No	003/103	No	No	No
J1980	No	No	No	003/103	No	No	No
J2001	No	No	No	003/103	No	No	No
J2400	No	No	No	003/103	No	No	No
J2510	No	No	No	003/103	No	No	No
J2540	No	No	No	003/103	No	No	No
J2547	No	18y & up	**View ICD Codes**	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 51 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2590	No	No	No	003/103	No	No	No
J2650	No	No	No	003/103	No	No	No
J2675	No	No	No	003/103	No	No	No
J2700	No	No	No	003/103	No	No	No
J2916	No	No	No	No	No	No	No
J3070	No	No	No	003/103	No	No	No
J3250	No	No	No	003/103	No	No	No
J3260	No	No	No	003/103	No	No	No
J3301	No	No	No	003/103	No	No	No
J3302	No	No	No	003/103	No	No	No
J3303	No	No	No	003/103	No	No	No
J3370	No	No	No	003/103	No	No	No
J3410	No	No	No	003/103	No	No	No
J7297	FP	12y – 65y	No	No	No	No	No
J7298 Females Only	FP	12y – 65y	No	No	No	No	No
J7300	FP	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 51 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7301	FP	No	No	No	No	No	No
J7302	FP	No	No	No	No	No	No
J7303	FP	No	No	No	No	No	No
90371	No	No	No	No	No	No	No
90656	No	19y & up	No	No	No	No	No
NOTE: See subsections A through G of this section for additional instructions.							
90658	No	19y & up	No	No	No	No	No
NOTE: See subsections A through G of this section for additional instructions.							
90673	No	19y-49y	No	No	No	No	No
90703	No	No	No	No	No	No	No
90707	No	19y-20y	No	No	No	No	No
90732	No	2y & up	No	No	No	No	No
NOTE: 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.							
90743	No	0-18y	No	No	No	No	No
90744	No	0-18y	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
90748	No	19y-20y	No	No	No	No	No
90749*	No	No	No	No	No	No	No
NOTE: Claim forms for procedure code 90749 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							

TOC not required

262.100 Children's Services Targeted Case Management Procedure Code ~~7-1-07~~10-1-22~~1~~

Providers of Children's Services targeted case management (TCM) must bill for services provided using the procedure code and modifiers shown in the table below. Providers must use this procedure code and the indicated modifiers when billing either electronically or on paper for Children's Services TCM services.

View or print the procedure codes for Children's Services Targeted Case Management (TCM) services.

~~Procedure Code~~	~~Modifier 1~~	~~Modifier 2~~	~~Description~~	~~Benefit Limit~~
~~T1017~~	~~U2~~	~~UA~~	~~Children's Services targeted case management~~	~~One (1) unit per client per day.~~

TOC not required

212.000 Summary of Coverage

~~7-1-09~~10-1-~~22~~1

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the $500.00 benefit limit for adults.

Medicaid dental procedure codes are listed in **Section 262.100** for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in **Section 262.200**. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. **Section 262.200** also lists the procedure codes that are benefit limited.

214.100 Tobacco Cessation Products and Counseling Services

~~2-1-20~~10-1-~~22~~1

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

Counseling services and benefits are defined below:

A. Prescribers must review the Public Health Service (PHS) guideline-based checklist with the patient.

B. The prescriber must retain the counseling checklist and file in the patient records for auditing. **View or print the checklist**.

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. For beneficiaries age twenty-one (21) and over, counseling procedures will count against the $500 adult dental benefit limit. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under that minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Beneficiaries who are pregnant are allowed up to four (4) 93-day courses of treatment per calendar year.

NOTE: The course of treatment is defined as three consecutive months.

F. If the beneficiary is in need of intensive tobacco cessation services, the provider may refer the beneficiary to an intensive tobacco cessation program: **View or print the Arkansas Be Well Referral Form.**

G. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

H. ~~D1320 —~~Tobacco counseling for the control and prevention of oral disease must be billed when the provider counsels and refers the beneficiary to an intensive tobacco cessation program.

I. ~~D9920 —~~Behavior management by report must be billed when tobacco counseling for the control and prevention of oral disease has been provided to the beneficiary.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

J. Refer to **Section 262.100** and **262.200** for procedure codes and billing instructions.

215.000 Child Health Services (EPSDT) Dental Screening

~~5-1-14~~10-1-~~22~~4

The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Services (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) periodic dental screening exam is limited to two screening exams every six (6) months plus one (1) day for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See **Section 262.100** to view the procedure code for periodic dental screening exams.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening exam twice per SFY. Extension of benefits is available in cases of medical necessity. **View or print form ADA-J430.** See **Section 262.100** for the interperiodic dental screening exam procedure code.

NOTE: ARKids First-B beneficiaries may also receive an interperiodic dental screening exam twice per SFY. There is no extension of benefits for ARKids First-B beneficiaries.

Extension of benefits requests, in addition to a narrative and any supporting documentation, should be submitted to the Division of Medical Services Dental Care Unit – ATTN Dental Extension of Benefits. **View or print the Division of Medical Services Dental Care Unit contact information**.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

216.200 Bitewing Radiographs

~~8-1-13~~10-1-~~22~~4

Bitewing radiographs are covered for beneficiaries of all ages. There are different limitations of coverage for beneficiaries under age 21 and for those beneficiaries age 21 and older.

The EPSDT periodic screening exam may include only two bitewings and is allowed every six (6) months plus one (1) day for beneficiaries under age 21. See **Section 262.100** for the appropriate procedure code.

Two bitewing films are allowed once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. See **Section 262.200** for appropriate procedure codes.

216.300 Intraoral Film

~~4-1-05~~10-1-~~22~~4

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code ~~D0220~~ must be used for the first film and procedure code ~~D0230~~ for each additional single film.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the beneficiary identification number and stapled to the back of the claim form, as noted in Section 216.000.

217.100 Dental Prophylaxis and Fluoride Treatment

~~8-1-14~~10-1-~~22~~4

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. Arkansas Medicaid covers fluoride varnish application, ADA code ~~D1206~~, 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 healthcare 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 Provider Enrollment. The course that meets the requirements outlined by the ACT 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.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Topical fluoride treatment or fluoride varnish is covered every six (6) months plus one (1) day for beneficiaries under age 21.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code ~~D1206~~, Topical Application of Fluoride Varnish.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

A. Periodic EPSDT screening exam (for beneficiaries under age 21).

B. Prophylaxis, topical fluoride and/or fluoride varnish.

C. Periapical X-rays, amalgam-composite restorations (except four or more surfaces).

D. Pulpotomies for deciduous teeth. (Pulpotomies are not a covered service for beneficiaries age 21 and over.)

E. Chrome crowns on deciduous teeth.

See Sections 262.100 and 262.200 for applicable codes.

218.000 Space Maintainers

~~7-1-09~~10-1-~~22~~24

Space maintainers are covered for beneficiaries under age 21 and require prior authorization. X-rays must be submitted with the request for prior authorization. When submitting a treatment plan or claim for space maintainers, identify the missing tooth in the tooth column on the ADA claim form and submit the X-ray to show the tooth for which the space is maintained. See Section 262.100 for applicable procedure codes.

Space maintainers are not covered for beneficiaries age 21 and over.

219.100 Amalgam Restorations

~~7-1-09~~10-1-~~22~~24

Amalgam restorations are to be used on all teeth distal to the cuspids for beneficiaries of all ages. When submitting a claim for amalgam restorations, the tooth (teeth) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. Amalgam restorations do not require prior authorization. If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate. See Sections 262.100 and 262.200 for applicable procedure codes.

219.200 Composite Resin Restorations

~~8-1-13~~10-1-~~22~~24

Composite-resin restorations may be performed for anterior teeth for beneficiaries of all ages. Four or more surface composite-resin restorations require prior authorization. When submitting a claim for composite restorations, the tooth number(s) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. **If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate**. See Sections 262.100 and 262.200 for applicable procedure codes.

Only one amalgam or composite restoration per surface is allowed every 2 years.

220.000 Crowns – Single Restorations Only

~~7-1-09~~10-1-~~22~~24

Crowns are covered for individuals of all ages.

A. Chrome (Stainless Steel) Crowns - The Medicaid Program will cover chrome (stainless steel) crowns on deciduous posterior teeth only as an alternative to two or three surface alloys. Medicaid will cover chrome crowns on permanent posterior teeth only for loss of cuspal function. Stainless steel crowns on deciduous teeth do not require prior authorization. Prior authorization is required for crowns on all permanent teeth.

B. Anterior Crowns - Prefabricated stainless steel or prefabricated resin crowns may be approved for anterior teeth for beneficiaries under age 14. Prior authorization is required, and X-rays must be submitted to substantiate need.

C. Cast Crowns - Medicaid does not cover cast crowns for posterior teeth.

D. Porcelain-to-Metal Crowns - Porcelain-to-metal crowns may be approved only in unusual cases for anterior incisors and cuspids for beneficiaries under age 21. These cases must be submitted for prior authorization (PA) with complete treatment plans for all teeth and

complete series X-rays or panoramic film with bitewings. Photographs are helpful, but are not required.

E. Post and Core in Addition to Crown - Medicaid does not cover core buildups or post and core buildups. This includes an amalgam filling with a stainless steel crown. An exception to this rule may be anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch.

Fillings are not allowed on tooth numbers with crowns within one year of the crown.

See Sections **262.100** and **262.200** for applicable procedure codes.

221.000 Endodontia

~~7-18-11~~10-1-~~22~~4

Pulpotomy for deciduous teeth may be performed without prior authorization for beneficiaries under age 21. **Pulpotomies are not covered for individuals age 21 and over.**

Current indications require carious exposure of the pulp. Payment for pulp caps is included in the fee for restorations and is not payable separately.

Endodontic therapy is not covered for individuals age 21 and over.

To be reimbursed, the completed endo-fill should conform to current standards, that is, complete obturation of all canals to within 1mm to 2mm of radiographic apex.

The fee for endodontic therapy does not include restoration to close a root canal access, but does include films for measurement control and post-op.

Medicaid does not cover endodontic retreatment, apexification, retrograde fillings or root amputation. **See Section 262.100** for applicable procedure codes.

222.000 Periodontal Procedures

~~7-1-09~~10-1-~~22~~4

Periodontal treatment is available for beneficiaries of all ages. When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and X-rays are required. Each quadrant to be treated must be indicated on separate lines when requesting prior authorization or payment. Prior authorization will require a report, a periochart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. See Sections **262.100** and **262.200** for applicable procedure codes.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs)

~~7-1-12~~10-1-~~22~~4

A. Benefits

Full and acrylic partial dentures are covered for beneficiaries of all ages. Full dentures or acrylic partial dentures may be approved for use instead of fixed bridges.

Beneficiaries age 21 and over are allowed only one complete maxillary denture and one complete mandibular denture per lifetime.

Beneficiaries age 21 and over are allowed only one upper and one lower partial per lifetime.

Repairs of dentures and partials are covered but are benefit-limited for beneficiaries age 21 and over. See Sections **262.100** and **262.200** for applicable procedure codes.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

B. Prior Authorization Requirements

Prior authorization is required for dentures (full or partial) for beneficiaries under the age of 21.

Prior authorization is required for partial dentures for beneficiaries age 21 and over.

Prior authorization is not required for full dentures for beneficiaries age 21 and over.

For dentures that require prior authorization, a complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by partial dentures, must be submitted with prior authorization requests. See Sections **262.100** and **262.200** for further information regarding prior authorization for dentures.

Prior authorization is required for repairs of dentures and partials for eligible beneficiaries of all ages. A history and date of original insertion must be submitted with the prior authorization request. See Sections **262.100** and **262.200** for applicable procedure codes.

C. Required Process for Submitting Adult Dentures and Partials to Dental Lab

For eligible Medicaid beneficiaries age 21 and over, all dentures, whether full or partial, must be manufactured by the Medicaid-contracted dental lab. **View or print contact information for Medicaid Dental Contractor.**

When Medicaid issues a prior authorization for partial dentures for a beneficiary age 21 and over, the Dental Lab Request Form with the prior authorization number is returned to the dental provider's office. When the dental provider receives the prior authorization, the authorization will be for a maximum of six (6) (three upper and three lower) limited oral evaluations/problem-focused visits ~~(D0140)~~ along with authorization for the diagnostic casts ~~(D0470)~~. The dental provider must then send the Medicaid-contracted dental lab the completed Dental Lab Request Form with the prior authorization number and models to make the adult partial dentures. **If the dental lab does not receive the Dental Lab Request Form, the lab will make the partial dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid. View or print contact information for Medicaid Dental Contractor.**

Though prior authorization is not required for full dentures for beneficiaries age 21 and over, the dental provider must send the Dental Lab Request Form and models directly to the Medicaid-contracted dental lab. The Dental Lab Request Form must clearly indicate that the beneficiary is a Medicaid beneficiary and the dentures are being requested pursuant to the Medicaid benefit plan. **If the dental lab does not receive the request form, the lab will make the full dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** The dental provider will be reimbursed for a maximum of six (6) (three upper and three lower) limited oral evaluations/problem-focused ~~(D0140)~~ visits and two (2) (one upper and one lower) diagnostic casts ~~(D0470)~~. **View or print contact information for Medicaid Dental Contractor.**

D. Patient Consent

Dental offices that render a patient edentulous must also fabricate dentures for the patient. If the patient has indicated that he or she is willing to pay out of pocket to have the dentures fabricated by the dental office and not through the contracted Medicaid Dental Lab, then the dental office must secure the patient's written consent on a form to be designed by the dental office and maintained in the patient's record. Beneficiaries who purchase dentures outside of the Medicaid dental program remain eligible for the Medicaid once-in-a-lifetime denture benefit.

225.100 Simple Extraction

~~7-1-09~~10-1-~~22~~4

Simple extractions may be performed without prior approval. Simple extractions of 3rd molars do not require prior authorization.

When a simple extraction evolves into a surgical extraction, providers must write a brief explanation of the circumstances if the problem is not indicated on the X-ray. Normally, surgical extractions imply sectioning, suturing and bone removal or any combination of these procedures. Providers must submit the claim, with the X-ray, for authorization and payment to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**. See Sections **262.100** and **262.200** for applicable procedure codes.

225.200 Surgical Extractions

~~9-1-13~~10-1-~~22~~4

Surgical extractions for beneficiaries of all ages require prior authorization and X-rays to substantiate need. The dental consultant may require a second opinion when reviewing treatment plans for extractions.

Surgical extractions performed on an emergency basis (See Section 234.000) for relief of pain may be reimbursed subject to the approval of a Medicaid dental consultant. In these cases, the claim with X-ray and a brief explanation should be submitted to the Division of Medical Services Dental Care Unit**.** **View or print the Division of Medical Services Dental Care Unit contact information**.

For beneficiaries under the age of 21, the fee for surgical extraction includes local anesthesia and routine post-operative care. See Sections **262.100** and **262.200** for applicable procedure codes. Anesthesia is not a covered service for beneficiaries 21 and over.

225.300 Traumatic Accident

~~7-1-09~~10-1-~~22~~4

In cases of traumatic accident and when time is of prime importance, the dental provider may perform the necessary procedure(s) immediately. The procedure code chart found in Sections **262.100** and **262.200** identifies the procedures that may be billed “By Report” and those which must be prior authorized before reimbursement may be made. The chart also indicates the procedures that require submission of X-rays. Pre- and post-operative X-rays, if requested, must be made available to the Division of Medical Services.

225.500 Deep Sedation and General Anesthesia

~~8-1-13~~10-1-~~22~~4

Providers administering general anesthesia services must possess the appropriate permit as required by Arkansas law. Services performed in the dental office must be documented in the patient’s record to include specific information on intubation, pharmacologic agents and amounts used, monitoring of vital signs and total anesthesia time. Prior authorization is required for deep sedation and general anesthesia procedures. General anesthesia and intravenous sedation will not be reimbursed for periods of time in excess of two (2) hours. ~~D9220 and D9248 a~~Are not allowed on the same day.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

These codes are subject to post payment review; therefore, providers should be prepared to justify utilization of these procedures and the amount of time patients were kept under deep sedation and general anesthesia.

227.000 Professional Visits

~~7-1-09~~10-1-~~22~~4

Professional visits are payable if prior authorized. Because it is not always possible to plan these calls, the provider should submit a claim with a concise explanation of the circumstances. These visits are subject to review by the dental consultant.

When a treatment is necessary and no procedure code is applicable, a written explanation of the treatment and the usual and customary fee charged to a private patient must be submitted to the Medicaid Program. The dental consultant will stipulate an exact fee to be paid if the treatment is authorized. See Sections **262.100** and **262.200** for applicable procedure codes.

262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21 ~~8-1-14~~10-1-~~22~~1

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

NOTE: Only physicians who have completed the training on dental caries and have an approved fluoride varnish certification on file with Provider Enrollment can bill for the fluoride varnish treatment. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Providers must check the Supplemental Eligibility Screen to verify that topical fluoride treatment or fluoride varnish was not applied by another Medicaid dental provider.

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

* Revenue code

**(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

** Prior authorization is required for panoramic X-rays performed on children under six years of age (See Section 216.100).

~~ADA Code~~	~~Description~~	~~PA Yes/No~~	~~Submit X-Ray with Treatment Plan Yes/No~~
Child Health Services (EPSDT) Dental Screening (See Section 215.000)			
~~D0120~~	~~**(CHS/EPSDT Dental Screening Exam)~~	~~No~~	~~No~~
~~D0140~~	~~**(CHS/EPSDT Interperiodic Dental Screening Exam)~~	~~No, but limited to two (2) per SFY~~	~~No~~
Radiographs (See Sections 216.000 – 216.300)			
~~D0210~~	~~Intraoral – complete series (including bitewings)~~	~~No~~	~~No~~
~~D0220~~	~~Intraoral – periapical – first film~~	~~No, but limited to five (5) per SFY~~	~~No~~

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D0230	Intraoral – periapical – each additional film	No, but limited to five (5) per SFY	No
D0240	Intraoral – occlusal film	No, but limited to five (5) per SFY	No
D0250	Extraoral – first film	No	No
D0260	Extraoral – each additional film	No, but limited to five (5) per SFY	No
D0272	Bitewings – two films	No	No
D0330	Panoramic film	No**	No
D0340	Cephalometric film	Yes	No
Tests and Laboratory			
D0350	Oral/facial photographic images	Yes	No
D0470	Diagnostic casts	Yes	No
Preventive			
Dental Prophylaxis (See Section 217.100)			
D1120	Prophylaxis – child ⁂(ages 0-9)	No	No
D1110	Prophylaxis – adult ⁂(ages 10-20)	No	No
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)			
D1206	Topical application of fluoride varnish (prophylaxis not included) – child ⁂ (ages 0-20)	No	No
D1208	Topical application of fluoride (prophylaxis not included) – child ⁂(ages 0-20)	No	No
Dental Sealants (See Section 217.200)			
D1351	Sealant per tooth ⁂(1st and 2nd permanent molars only)	No	No
Space Maintainers (See Section 218.000)			
D1510	Space maintainer – fixed – unilateral	Yes	Yes
D1515	Space maintainer – fixed – bilateral	Yes	Yes
D1525	Space maintainer – removable bilateral	Yes	Yes
Restorations (See Sections 219.000 – 219.200)			
Amalgam Restorations (including polishing) (See Section 219.100)			
D2140	Amalgam – one surface	No	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D2150	Amalgam – two surfaces	No	No
D2160	Amalgam – three surfaces	No	No
D2161	Amalgam – four or more surfaces	No	No
Composite Resin Restorations (See Section 219.200)			
D2330	Resin – one surface, anterior, permanent	No	No
D2331	Resin – two surfaces, anterior, permanent	No	No
D2332	Resin – three surfaces, anterior, permanent	No	No
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes
Crowns – Single Restoration Only (See Section 220.000)			
D2710	Crown – resin (laboratory)	Yes	Yes
D2752	Crown – porcelain ceramic substrate	Yes	Yes
D2920	Re-cement crown	No	Yes
D2930	Prefabricated stainless steel crown – primary	No	No
D2931	Prefabricated stainless steel crown – permanent	Yes, but no PA required when billed for tooth numbers 3, 14, 19 and 30.	Yes
Endodontia (See Section 221.000)			
Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration)	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes	No
Endodontic (Root Canal) therapy (including treatment plan, clinical procedures and follow-up care)			
D3310	Anterior tooth (excluding final restoration)	No	No
D3320	Bicuspid tooth (excluding final restoration)	No	No
D3330	Molar (excluding final restoration)	No	No
Periapical Services			
D3410	Apicoectomy (per tooth) – first root	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Periodontal Procedures (See Section 222.000)			
Surgical Services (including usual postoperative services)			
D4341	Periodontal scaling and root planing	Yes	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes
Complete dentures (Removable Prosthetics Services) (See Section 223.000)			
D5110	Complete denture – maxillary	Yes	Yes
D5120	Complete denture – mandibular	Yes	Yes
Partial Dentures (Removable Prosthetic Services) (See Section 223.000)			
D5211	Upper partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
D5212	Lower partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
Repairs to Partial Denture (See Section 223.000)			
D5610	Repair acrylic saddle or base	Yes	No
D5620	Repair cast framework	Yes	No
D5640	Replace broken teeth – per tooth	Yes	No
D5650	Add tooth to existing partial denture	Yes	No
Fixed Prosthodontic Services (See Section 224.000)			
D6930	Re-cement bridge	Yes	No
Oral Surgery (See Section 225.000)			
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)			
D7111	Extraction, coronal remnants-deciduous tooth	No	No
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes
D7220	Removal of impacted tooth – soft tissue	Yes	Yes
D7230	Removal of impacted tooth – partially bony	Yes	Yes
D7240	Removal of impacted tooth – completely bony	Yes	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Other Surgical Procedures			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes	Yes
D7280	Surgical exposure of impacted or un-erupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	Yes
D7285	Biopsy of oral tissue – hard	Yes	Yes
D7286	Biopsy of oral tissue – soft	Yes	Yes
Osteoplasty for Prognathism, Micrognathism or Apertognathism			
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No
Frenulectomy			
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes	Yes
Orthodontics (See Section 226.000)			
Minor Treatment of Control Harmful Habits			
D8210	Removable appliance therapy	Yes	Yes
D8220	Fixed appliance therapy	Yes	Yes
Comprehensive Orthodontic Treatment – Permanent Dentition			
D8070	Class I Malocclusion	Yes	Yes
D8080	Class II Malocclusion	Yes	Yes
D8090	Class III Malocclusion	Yes	Yes
Other Orthodontic Devices			
D8999	Unspecified orthodontic procedure, by report	Yes	Yes
Anesthesia			
D9220	General Anesthesia – first 30 minutes	Yes	Yes
D9221	General Anesthesia – each 15 minutes	Yes	No
D9230	Analgesia N_20	No, but requires report for request for more than 1 unit per day	No
D9248	Non-I.V. Conscious Sedation	Yes and requires report	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Consultations (See Section 214.000)			
D9310	⁂(Second opinion examination) Consultation, diagnostic service provided by dentist or physician other than practitioner providing treatment	Yes	No
Smoking Cessation			
D1320	Tobacco counseling for the control and prevention of oral disease – Counseling and referral by a provider to a tobacco cessation program	No	No
D9920	Behavior Management by Report – Tobacco counseling received from the provider for the control and prevention of oral disease	No	No
Unclassified Treatment			
D9110	Palliative treatment with dental pain	Yes	No

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older

8-1-1310-1-224

The following list shows the procedure code, procedure code description, whether or not prior authorization is required, whether an X-ray should be submitted with a treatment plan and if there is a benefit limit on a procedure.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates **"Yes, $500.00",** then that item, when used in combination with other items listed, cannot exceed the $500.00 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If **"No"** is shown, the item is not benefit limited.

NOTE: The use of the symbol, ⁂, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
Dental Screening (See Section 215.000)				
D0120	Periodic oral evaluation	No	No	Yes-$500 Yes-1 per year

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
D0140	Limited oral evaluation-problem focused	No	No	Yes-$500 Yes-12 per year
Radiographs (See Sections 216.000 – 216.300)				
D0210	Intraoral – complete series (including bitewings)	No	No	Yes-$500 Yes-1 per 5 years
D0220	Intraoral – periapical – first film	No	No	Yes-$500 Yes-5 per year
D0230	Intraoral – periapical – each additional film	No	No	Yes-$500 Yes-5 per year
D0272	Bitewings – two films	No	No	Yes-$500 Yes-1 per year
D0330	Panoramic film	No	No	Yes-$500 Yes-1 per 5 years
Tests and Laboratory				
D0470	Diagnostic Casts (full denture)	No	No	Yes-$500
	Diagnostic Casts (partial denture)	Yes	Yes	Yes-4 per lifetime
Dental Prophylaxis (See Section 217.100)				
D1110	Prophylaxis – adult	No	No	Yes-$500 Yes-1 per year
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)				
D1204	Topical application of fluoride (prophylaxis not included) – adult	No	No	Yes-$500 Yes-1 per year
Restorations (See Sections 219.000 – 219.200)				
Amalgam Restorations (including polishing) (See Section 219.100)				
D2140	Amalgam – one surface, primary or permanent	No	No	Yes-$500
D2150	Amalgam – two surfaces, primary or permanent	No	No	Yes-$500
D2160	Amalgam – three surfaces, primary or permanent	No	No	Yes-$500
D2161	Amalgam – four or more surfaces, primary or permanent	No	No	Yes-$500
Composite Resin Restorations (See Section 219.200)				
D2330	Resin – one surface, anterior, permanent	No	No	Yes-$500

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
D2331	Resin – two surfaces, anterior, permanent	No	No	Yes $500
D2332	Resin – three surfaces, anterior, permanent	No	No	Yes $500
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes	Yes $500
Crowns – Single Restoration Only (See Section 220.000)				
D2920	Re-cement crown	No	Yes	Yes $500
D2931	Prefabricated stainless steel crown – permanent	Yes, but no PA required when billed for tooth numbers 3, 14, 19 and 30.	Yes	Yes $500
Surgical Services (including usual postoperative services)				
D4341	Periodontal scaling and root planing four or more contiguous	Yes	Yes	Yes $500
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Yes	Yes	Yes $500
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes	Yes $500
Repairs to Complete and Partial Dentures (See Section 223.000)				
D5410	Adjust complete denture-maxillary	No	No	Yes $500 Yes-3 per lifetime
D5411	Adjust complete denture-mandibular	No	No	Yes $500 Yes-3 per lifetime
D5610	Repair acrylic saddle or base	Yes	No	Yes-$500
D5640	Replace broken teeth – per tooth	Yes	No	Yes $500
D5650	Add tooth to existing partial denture	Yes	No	Yes $500
D5730	Reline complete maxillary denture (chairside)	No	No	Yes $500 Yes-1 every 3 years
D5731	Reline lower complete mandibular denture (chairside)	No	No	Yes $500 Yes-1 every 3 years

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No	Benefit Limit Yes/No
Fixed Prosthodontic Services (See Section 224.000)				
D6930	Re-cement bridge	Yes	No	Yes-$500
Oral Surgery (See Section 225.000)				
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)				
D7140	Single tooth	No	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)				
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes	No
D7220	Removal of impacted tooth – soft tissue	Yes	Yes	No
D7230	Removal of impacted tooth – partially bony	Yes	Yes	No
D7240	Removal of impacted tooth – completely bony	Yes	Yes	No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes	No
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes	Yes-$500
Other Surgical Procedures				
D7285	Biopsy of oral tissue – hard	Yes	Yes	Yes-$500
D7286	Biopsy of oral tissue – soft	Yes	Yes	Yes-$500
D7310	Alveoplasty in conjunction with extractions-four or more teeth	Yes	No	Yes-$500
D7472	Removal of torus palatinus	Yes	No	Yes-$500 1 per lifetime
D7473	Removal of torus mandibularis	Yes	No	Yes-$500 1 per lifetime
Osteoplasty for Prognathism, Micrognathism or Apertognathism				
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No	Yes-$500

~~ADA Code~~	~~Description~~	~~PA Yes/No~~	~~Submit X-Ray with Treatment Plan Yes/No~~	~~Benefit Limit Yes/No~~
Unclassified Treatment				
~~D9110~~	~~Palliative treatment with dental pain~~	~~Yes~~	~~No~~	~~Yes $500~~
Smoking Cessation				
~~D1320~~	~~Tobacco counseling for the control and prevention of oral disease – Counseling and referral by a provider to a tobacco cessation program~~	~~No~~	~~No~~	~~Yes $500~~ ~~2 counseling sessions per SFY~~
~~D9920~~	~~Behavior Management by Report – Tobacco counseling received from the provider for the control and prevention of oral disease~~	~~No~~	~~No~~	~~Yes $500~~ ~~2 counseling sessions per SFY~~

262.400 Billing Instructions – ADA Claim Form - Paper Claims Only

~~8-1-21~~10-1-~~22~~1

Dental providers must complete the ADA claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information.**

Completed claim forms should be forwarded to the Claims Department. **View or print the Claims Department contact information.**

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	

Field Number and Name	Instructions for Completion
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the patient Medicaid ID number.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial

Field Number and Name	Instructions for Completion
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility The full list is available online at http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.

Field Number and Name	Instructions for Completion
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Required.
55. License Number	Optional.

Field Number and Name	Instructions for Completion
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. View or print form ADA-J430.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

262.500 Special Billing Procedures for ADA Claim Form

~~7-1-09~~10-1-22~~1~~

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials
3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made for beneficiaries under age 21, the dentist must use procedure code ~~D0210~~ rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code ~~D0220~~ must be used for the first film and procedure code ~~D0230~~ for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the beneficiary identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals for beneficiaries under age 21. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. View or print the Division of Medical Services Dental Care Unit contact information.

E. Prophylaxis and fluoride must be indicated on the same line of the form using code ~~D1201~~. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code ~~D0220 and D0230~~, intraoral single film. When a complete series is made for beneficiaries under age 21, providers must use code ~~D0210~~ rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Use procedure code ~~D1110~~ for prophylaxis-adult, ages 10 through 99, and procedure code ~~D1120~~ for prophylaxis-child, ages 0 through 9.

263.100 CPT Procedure Codes

~~12-9-11~~10-1-~~22~~4

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

A. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter “E” in Field 24H.

B. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor’s office, patient’s home, nursing home and skilled nursing facility.

C. Radiology procedures are payable only in the dentist’s office. The place of service (POS) codes may be found in Section 262.300 of this manual. **These services require a PCP referral**.

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each service must be billed on a separate form. See Section 263.300 for complete billing instructions.

A. When billing for extractions ~~(procedure code 41899)~~, a listing of teeth extracted by date, tooth number and ADA code number must be attached.

B. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

See the Arkansas Medicaid Dental Fee Schedule for covered procedure codes.

263.110 CPT Procedure Codes that Require Prior Authorization Before Performing the Procedure

~~12-9-11~~10-1-~~22~~4

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider’s manual.

~~11960~~	~~11970~~	~~11971~~	~~21079~~	~~21080~~	~~21081~~	~~21082~~	~~21083~~
~~21084~~	~~21085~~	~~21086~~	~~21087~~	~~21088~~	~~21089~~	~~21120~~	~~21121~~
~~21122~~	~~21123~~	~~21125~~	~~21127~~	~~21137~~	~~21138~~	~~21139~~	~~21145~~
~~21146~~	~~21147~~	~~21150~~	~~21151~~	~~21154~~	~~21155~~	~~21159~~	~~21160~~
~~21172~~	~~21175~~	~~21179~~	~~21180~~	~~21181~~	~~21182~~	~~21183~~	~~21184~~
~~21188~~	~~21193~~	~~21194~~	~~21195~~	~~21196~~	~~21198~~	~~21208~~	~~21209~~
~~21244~~	~~21245~~	~~21246~~	~~21247~~	~~21248~~	~~21249~~	~~21255~~	~~21256~~
~~30400~~	~~30410~~	~~30420~~	~~30430~~	~~30435~~	~~30450~~	~~30462~~	~~67900~~
~~69300~~							

263.310 Completion of CMS-1500 Claim Form

~~9-1-1410-1-224~~

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	

Field Name and Number	Instructions for Completion
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.300 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from **Section 262.100** or **Section 262.200**.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number		Instructions for Completion
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
	a. (blank)	Enter NPI of the billing provider or
	b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

263.400 Special Billing Procedure for the CMS-1500 Claim Form

~~7-1-07~~10-1-~~22~~4

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary. View a CMS-1500 sample form. These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: Procedure code ~~99238~~ (Hospital Discharge Day Management) is payable for medical services. Procedure code ~~99238~~ may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes ~~99221 through 99233~~). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible beneficiaries of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible beneficiaries under the age of 21 years participating in the Child Health Services (EPSDT) Program.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.410 Multiple Quadrants Billing Instructions

~~7-1-07~~10-1-~~22~~4

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a patient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

~~D1110~~	~~D1120~~	~~41872~~	~~41874~~

263.420 Anesthesia Services

~~7-1-07~~10-1-~~22~~4

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the Current Procedural Terminology (CPT-4) code book.

B. Providers must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, any applicable modifier(s) are also required.

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G.

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires medical care services. When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, and must bill "1" unit of service.

Procedure code ~~00170~~ may be billed by oral surgeons for anesthesia for inpatient or outpatient dental surgery using place of service code 24, 21, 22, or 11, as appropriate. The code does not require prior approval for anesthesia claims.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.421 Anesthesia Procedure Codes

~~7-1-07~~10-1-~~22~~4

Oral surgeons must use the following anesthesia procedure codes when billing on paper.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

~~00100~~	~~00102~~	~~00103~~	~~00140~~	~~00160~~	~~00162~~	~~00164~~	~~00170~~
~~00172~~	~~00174~~	~~00176~~	~~00190~~	~~00192~~	~~00300~~		

TOC not required

214.300 Foster Care Intake Physical Examination in the EPSDT Program

~~10~~-1-~~08~~22~~1~~

Arkansas Medicaid beneficiaries entering the Arkansas foster care system are required to receive an intake physical examination within the first seventy two (72) hours. If the EPSDT provider who performs the screening is not the beneficiary's PCP, the intake physical examination should be billed with procedure codes ~~99381-99385~~ and modifiers **EP** and **H9**.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Billing with these procedure codes and modifiers will allow the claim to be submitted for payment without a referral from the beneficiary's PCP and will alert the system not to count the screen toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

If the EPSDT provider who performs the screen is the beneficiary's PCP, the intake physical exam should be billed with procedure codes ~~99391-99395~~ and modifiers **EP** and **H9**. Billing with these procedure codes and modifiers will allow the claim to be submitted for payment and will not count toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

Procedure codes ~~99381-99385~~ and ~~99391-99395~~**,** in conjunction with the **EP and H9 modifiers,** are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system.

215.100 Schedule for Child Health Services (EPSDT) Medical/Periodicity Screening

~~1-1-2010~~-1-~~221~~

The periodic EPSDT screening schedule has been changed in accordance with the most recent recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 20 years.

Age			
3 years	8 years	13 years	18 years
4 years	9 years	14 years	19 years
5 years	10 years	15 years	20 years
6 years	11 years	16 years	
7 years	12 years	17 years	

Most medical and hearing screens for children require a PCP referral before the screens may occur. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See **Section 242.100** for procedure codes.

215.210 Health and Developmental History

~~10~~-1~~3-03~~-~~221~~

A health and developmental history should be obtained from the parent or other responsible adult who is familiar with the child's health history. The child's height and weight should also be recorded and compared with the ranges considered normal for children of that age. See **Section 242.100** for procedure codes.

215.220 Unclothed Physical Examination

10-13-03-22

An unclothed physical examination should be performed to note obvious physical defects including orthopedic, genital, skin, and other observable deviations. If there is evidence that the child has been physically abused, this should be reported to the authorities according to state law requirements. See **Section 242.100** for procedure codes.

215.230 Developmental Assessment

10-13-03-22

A developmental assessment should be obtained by history and observation of the child or by one of the developmental tests. This portion of the screening could include assessment of eye-hand coordination, gross motor function (walking, hopping, climbing), fine motor skills (use of finger dexterity and hand usage), speech development, daily living personal skills such as dressing, feeding and grooming oneself, behavioral development and proofs of mind with body integration. See **Section 242.100** for procedure codes.

215.240 Visual Evaluation

1-15-1110-1-22

A visual evaluation is required for all children receiving Child Health Services (EPSDT) screening. The age-specific procedures (Section 216.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require Titmus machine or other ophthalmological testing. Subjective testing may be provided as part of a vision screening. See **Section 242.100** for procedure codes.

215.250 Hearing Evaluation

10-13-03-22

A hearing evaluation is required for all children receiving a Child Health Services (EPSDT) screening. The age-specific procedures (Section 217.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require machine audiology testing. Subjective testing may be provided as part of a hearing screening. See **Section 242.100** for procedure codes.

215.260 Oral Assessment

10-13-03-22

An oral assessment is considered part of the full Child Health Services (EPSDT) screening. A referral to a dentist for an oral screen is offered beginning at childbirth. See **Section 242.100** for procedure codes.

215.270 Laboratory Procedures (CPT Codes)

3-1-1410-1-22

Laboratory procedures should be performed as appropriate for the child's age and population group. See Sections 215.310 through 215.340 for age and testing recommendations. See Section 219.000 for specific blood lead testing and **Section 242.150** for CPT codes.

215.280 Nutritional Assessment

10-13-03-22

Physical and laboratory determinations carried out in the screening process will usually yield information useful in assessing nutritional status. A child having any detectable nutritional deficiencies should be treated or referred to the proper resource for counseling. This component of the medical screen is included in the full Child Health Services (EPSDT) screening. See **Section 242.100** for procedure codes.

215.290 Health Education

~~2-1-2010~~**-1-22**~~1~~

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive physical examination, visual, hearing or dental screening provides the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. See **Section 242.100** for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

A. Counseling Visits:

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
~~99406*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15 minutes)~~
~~99406*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15 minutes provided to parents of children birth through twenty (20) years of age)~~
~~99407*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intensive, 30 minutes)~~
~~99407*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30 minutes provided to parents of children birth through twenty (20) years of age)~~

***** Exempt from PCP referral requirements.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Referral of patient to an intensive tobacco cessation referral program.

C. Can be billed in addition to an office visit or EPSDT.

D. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. These counseling sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. View or Print the Arkansas Be Well Referral Form.

Refer to Section 257.000 and Section 292.900 of the Physician's manual for more information.

216.000 Vision Screen

~~4-1-09~~10-1-~~22~~4

An EPSDT periodic complete medical screen includes both hearing and vision screens. Providers must not bill an EPSDT periodic vision or hearing screen on the same day, or within seven (7) days of an EPSDT periodic complete medical screen by the same or different providers. The above combinations represent a duplication of services.

The provider must administer an age-appropriate vision assessment. See Section 242.100 for procedure codes.

Vision services are subject to their own periodicity schedule; however, when the periodicity schedule coincides with the schedule for periodic complete medical screen-, vision screens must be included as part of the required minimum periodic complete medical screening services. Vision screens are exempt from the PCP referral requirement.

See Sections 215.310 through 215.340 for the age-specific vision screening periodicity schedule.

At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses.

218.000 Dental Screening Services

1~~0~~-1~~3-03~~-~~22~~4

Although an oral assessment may be part of a medical screen, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child once per state fiscal year (July 1 through June 30). See Section 242.100 for procedure codes.

A Child Health Services (EPSDT) interperiodic dental screen may be completed as often as medically necessary, but must be prior authorized in order for the claim to be paid. Refer to Section 220.000 for an explanation of the prior authorization process.

Dental screens are exempt from the primary care provider (PCP) referral requirement.

Dental Services
At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. The periodicity schedule for other EPSDT services may not govern the schedule for dental services.

A child should receive his or her first dental screen examination within 6 months after eruption of the first primary tooth but no later than 12 months of age.

220.000 PRIOR AUTHORIZATION

~~1-15-11~~10-1-~~24~~2

Prior authorization is required for the interperiodic dental screen and must be requested on the ADA claim form. Refer to the Dental Provider Manual for details regarding the prior authorization process. See Section 242.100 for procedure codes.

242.100 Procedure Codes

~~2-1-20~~10-1-~~22~~4

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Procedure Code	Modifier 1	Modifier 2	Description
99381-99385	EP	U1	EPSDT Periodic Complete Medical Screen (New Patient)
99381-99385[1]	EP	H9	EPSDT Periodic Complete Medical Screen (Foster Care)
99391-99395	EP	U2	EPSDT Periodic Complete Medical Screen (Established Patient)
99391-99395[1]	EP	H9	EPSDT Periodic Complete Medical Screen (Foster Care)
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)
99173[1]	EP		EPSDT Periodic Vision Screen
V5008[1]	EP		EPSDT Periodic Hearing Screen
T1502	EP		Admin. of oral, intramuscular, or subcutaneous medication by health care agency/professional, per visit.
DO120[1]			CHS/EPSDT Oral Examination
D0140[1]			EPSDT Interperiodic Dental Screen, with prior authorization
99401	EP		EPSDT Health Education - Preventive Medical Counseling
99406[1]	SE		**(Smoking and tobacco use cessation counseling visit; intermediate, 15-minutes)
99406	CG		** (Smoking and tobacco use cessation counseling visit, intermediate, 15-minutes provided to parents of children birth through twenty (20) years of age)
99407[1]	SE		**(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)
99407	CG		** (Smoking and tobacco use cessation counseling visit, intensive, 30-minutes provided to parents of children birth through twenty (20) years of age)
99070	EP		Supplies and materials provided by physician over and above those covered by the office visit or other services rendered.
36415[2]			Collection of venous blood by venipuncture
83655			Lead

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

NOTES

A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.

B. New born screenings can be performed by a Certified Nurse Midwife or Nurse Practitioner without a PCP referral.

C. Procedure codes ~~**99381-99385** and **99391-99395**~~**,** used in conjunction with the **EP and H9 modifiers,** are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)

D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. ~~**99460, 99461, and 99463 m**~~**May be billed on the CMS-1500 claim form, by paper or electronically.** **(View or print a CMS-1500 sample form.)** ~~**99460, 99461 and 99463 m**~~**May also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**

E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.

F. Immunizations and laboratory tests may be billed separately from comprehensive screens.

G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.

H. ~~**T1502** m~~May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections ONLY when the provider administers, but does not supply the drug.

1. ~~**T1502** c~~Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
2. ~~**T1502** c~~Cannot be billed to administer any medication given for family planning purposes.
3. ~~**T1502** c~~Cannot be billed when the drug administered is not FDA approved.

I. 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. Claims require National Place of Service code “11”. Procedure code ~~**99070**~~ is limited to beneficiaries under age twenty-one (21).

242.110 Newborn Care

10-1-15221

For routine newborn care following a vaginal delivery or C-section, procedure code 99460, 99461 or 99463 should be used one time to cover all newborn care visits by the attending physician. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes 99460, 99461 and 99463.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

These procedure codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), which is considered to be the initial newborn care/EPSDT screen in hospital. These procedure codes should not be used for illness care (e.g. neonatal jaundice). Providers may refer to the physician manual for necessary illness codes.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis for all providers **(View ICD Codes.)** Refer to the appropriate manual(s) for additional information about newborn screenings.

242.120 Billing Exceptions

10-1-15221

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

All EPSDT procedure codes must be billed on the CMS-1500 claim form with the following exceptions.

A. Dental Billing

1. Procedure code D0120 must be billed on the American Dental Association (ADA) claim form. **View or print the ADA claim form.**
2. Prior authorization for procedure code D0140 must be requested on the ADA claim form.
3. Procedure code D0140 for an interperiodic dental screen must be billed on the ADA claim form.

B. When billing EPSDT screening codes, providers are not limited to the following diagnosis codes: **(View ICD Codes.)** The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis **(View ICD Codes.)**

242.140 Vaccines for Children Program

3-15-1510-1-212

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Department of Health. **View or print Arkansas Department of Health contact information.**

Vaccines available through the VFC program are covered for Medicaid-eligible children. Only the administrative fee is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**.

All procedure codes under the VFC program must be billed electronically or on paper, using either the CMS-1500 claim form or the CMS-1450 claim form.

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

Providers may consult the Physician's manual to view the list of vaccines that are non-VFC but are covered for beneficiaries who are 19 and 20 years of age. The following list contains the vaccines available through the VFC program.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Procedure Code	M1	M2	Age Range	Vaccine Description
90633*	EP	TJ	12 months-18 years	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
90634*	EP	TJ	12 months-18 years	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use
90636	EP	TJ	18 years only	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use
90645	EP	TJ	0-18 years	Hemophilus influenza b (Hib) HbOC conjugate (4 dose schedule) for intramuscular use
90646	EP	TJ	0-18 years	Hemophilus influenza b (Hib) PRP-D conjugate for booster use only, intramuscular use
90647	EP	TJ	0-18 years	Hemophilus influenza b (Hib) PRP-OMP conjugate (3 dose schedule), for intramuscular use
90648	EP	TJ	0-18 years	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
90649	EP	TJ	9-18 years	Human Papilloma Virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), three dose schedule, for intramuscular use
90650	EP	TJ	9-18 years	Human Papilloma Virus (HPV) vaccine, types 16, 18, bivalent, three dose schedule, for intramuscular use
90654	EP	TJ	18 years	Influenza virus vaccine, split virus, preservative free, for intradermal use, is covered for healthy individuals **who are not pregnant**
90655	EP	TJ	6 months-35 months	Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use
90656	EP	TJ	3 years-18 years	Influenza virus vaccine, split virus, preservative free, for use in individuals 3 years and above, for intramuscular use
90657	EP	TJ	6 months-35 months	Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use
90658	EP	TJ	3 years-18 years	Influenza virus vaccine, split virus, for use in individuals 3 years and above, for intramuscular use
90660	EP	TJ	5 years-18 years (not pregnant)	Influenza virus vaccine, live, for intranasal use
90669	EP	TJ	0-4 years	Pneumococcal conjugate vaccine polyvalent, for children under 5 years, for intramuscular use

Procedure Code	M1	M2	Age Range	Vaccine Description
90670	EP	TJ	6 weeks-5 years	Pneumococcal conjugate vaccine, 13 Valent for intramuscular use
90672	EP	TJ	2-18 years	Influenza virus vaccine, quadrivalent, when administered to individuals for intramuscular use, is covered for healthy individuals
90673	EP	TJ	18 years	Influenza virus vaccine, trivalent, derived from recombinant DNA (RIV3), hemagglutinin (HA) protein only, preservative free, for intramuscular use
90680**	EP	TJ	6 weeks to 32 weeks	Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
90681	EP	TJ	6 weeks to 32 weeks	Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use
90685	EP	TJ	6 months through 35 months	Influenza virus vaccine, quadrivalent, split virus, preservative free, for intramuscular use
90686	EP	TJ	3-18 years	Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals for intramuscular use, is covered for healthy individuals **who are not pregnant**
90688	EP	TJ	3-18 years	Influenza virus vaccine, quadrivalent, split virus, for intramuscular use, is covered for healthy individuals **who are not pregnant**
90696	EP	TJ	4-6 years	Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4 years through 6 years of age, for intramuscular use
90698	EP	TJ	0-4 years	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use
90700	EP	TJ	0-6 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, for intramuscular use
90702	EP	TJ	0-6 years	Diphtheria and tetanus toxoids (DT) absorbed when administered to individuals younger than 7 years, for intramuscular use
90707	EP	TJ	0-18 years	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
90710*	EP	TJ	0-18 years	Measles, mumps, rubella, and Varicella vaccine (MMRV), live, for subcutaneous use
90713	EP	TJ	0-18 years	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use
90714	EP	TJ	7-18 years	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals 7 years or older, for intramuscular use

Procedure Code	M1	M2	Age Range	Vaccine Description
90715*	EP	TJ	7-18 years	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), for use in individuals 7 years or older, for intramuscular use
90716	EP	TJ	0-18 years	Varicella virus vaccine, live, for subcutaneous use
90720	EP	TJ	0-18 years	Diphtheria, tetanus toxoids and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
90721	EP	TJ	0-18 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib), for intramuscular use
90723	EP	TJ	0-18 years	Diphtheria, tetanus toxoids and acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DTaP-HepB-IPV) (for intramuscular use
90732	EP	TJ	2-18 years	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals for subcutaneous or intramuscular use
90734*	EP	TJ	0-18 years	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use
90743	EP	TJ	0-18 years	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
90744	EP	TJ	0-18 years	Hepatitis B vaccine, pediatric/adolescent (3 dose schedule), for intramuscular use
90747	EP	TJ	0-18 years	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use
90748	EP	TJ	0-18 years	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

242.141 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-~~22~~4

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

242.150 Limitation for Laboratory Procedures Performed as Part of EPSDT Screens

~~3-1-14~~10-1-224

Child Health Services (EPSDT) screens do not include laboratory procedures unless the screen is performed by the beneficiary's primary care physician (PCP) or is conducted in accordance with a referral from the PCP.

The following tests are exempt from this limitation and may continue to be billed in conjunction with an EPSDT screen performed in accordance with existing Medicaid policy:

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

~~Procedure Code~~	~~Description~~
~~81000~~	~~Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy~~
~~81001~~	~~Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy~~
~~81002~~	~~Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy~~
~~83020~~	~~Hemoglobin, electrophoresis (e.g., AZ, S, C)~~
~~83655~~	~~Lead~~
~~85013~~	~~Blood count; spun microhematocrit~~
~~85014~~	~~Blood count; other than spun hematocrit~~
~~85018~~	~~Blood count, hemoglobin~~
~~86580~~	~~Skin test; tuberculosis, intradermal~~

Claims for laboratory tests, other than those specified above, performed in conjunction with an EPSDT screen will be denied, unless the screen is performed by the PCP or in accordance with a referral from the PCP.

The following screens will be affected by this policy.:

Procedure Code	Modifier 1	Modifier 2	Description
99381-99385	EP	U1	EPSDT Periodic Complete Medical Screen (New Patient)
99391-99395	EP	U2	EPSDT Periodic Complete Medical Screen (Established Patient)

242.300 Billing Instructions – Paper Only

11-1-1710-1-22

To bill for a Child Health Services (EPSDT) screening service, use the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. **View or print a sample CMS-1500 form.**

Each screening should be billed separately, providing the appropriate information for each of the screening components.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

With the exception of codes 99201-99215 (office medical services), 99341-99353 (home medical services) and 99221-99223, 99431, 99231-99233 and 99238 (hospital inpatient medical services), specific procedures may be used at the provider's discretion as long as the federally-mandated components (refer to Section 215.000) have been included in the screening package.

Medical services such as immunizations and laboratory procedures may also be billed on the CMS-1500 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

Claims for Child Health Services (EPSDT) dental services are to be billed on the ADA claim form. For dental screening to be paid, the ADA claim form must be completed and the box marked "child" in Field 2 must be checked.

Claims for Child Health Services (EPSDT) visual services are to be billed on the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. **View or print a sample CMS-1500 form.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if applicable information is omitted. Claims should be typed whenever possible.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

TOC not required

262.110 FQHC Encounter Service

~~11-1-17~~10-1-22~~1~~

FQHCs bill Medicaid for a core services encounter (which includes all services and supplies incident to the encounter) with procedure code ~~T1015~~, "FQHC Encounter Service."

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

Use type of service code 9 (paper claims only) with ~~T1015~~. Medicaid pays the facility's current established rate for each encounter.

262.120 Telemedicine

~~11-1-17~~10-1-22~~1~~

Use procedure code ~~T1014~~ and type of service code Y (paper claims only) to indicate telemedicine charges.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

The charge associated with this procedure code should be an amount attributable to the telemedicine service, such as line (or wireless) charges. Medicaid will deny the charge and capture it in the same manner as with ancillary charges.

262.130 Obstetric and Gynecologic Encounters

~~1~~0-1~~3-03~~-22~~1~~

Bill for the following obstetric and gynecologic procedures with the CPT procedure codes indicated and type of service code 2 (paper claims only).

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

~~58120~~	~~59410~~	~~59515~~	~~59812~~	~~59820~~

For settlement purposes, each of these procedures is considered an encounter.

262.140 Family Planning

~~1~~0-1~~3-03~~-22~~1~~

Bill Medicaid for family planning services with applicable procedure codes listed in Sections **262.141** through **262.152**.

262.141 Family Planning and Post-Sterilization Visits

~~11-1-17~~10-1-22~~1~~

Bill for family planning visits and post-sterilization visits with type of service code A (paper billing only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

~~National Code~~	~~Required Modifier~~	~~Revenue Code Description~~
~~99402~~	~~FP~~ ~~UA~~ ~~UB~~	~~Basic Family Planning Visit~~

National Code	Required Modifier	Revenue Code Description
99401	FP UA UB	Periodic Family Planning Visit

262.142 Family Planning Procedures

11-1-1710-1-221

Bill for family planning procedures with a type of service code A (paper billing only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

11977	11981	55250	55450	58300	58301
58600	58605	58615	58661	58670	58671
58700					

262.143 Contraceptives

11-1-1710-1-221

Bill for contraceptives with type of service code A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

National Code	Required Modifier	Revenue Code Description
A4260	FP	Implantable Contraceptive Capsule (Norplant System) Kit
J7297	FP	Liletta (IUD)
J7298	FP	Mirena (IUD)
J7300	FP	Paragard T380A (IUD)
J7301	FP	Skyla (IUD)

262.144 Contraceptive Injections—Depo-Provera

11-1-1710-1-221

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

National Code	Required Modifier
J1050	FP

262.151 Local Procedure Codes

11-1-1710-1-221

Bill for family planning laboratory procedures with type of service code A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

National Code	Required Modifier	Revenue Code Description
88302	FP	Surgical pathology, complete procedure, elective sterilization
88302	FP U2	Surgical pathology, professional component, elective sterilization
88302	FP U3	Surgical pathology, technical component, elective sterilization

262.152 National Procedure Codes

11-1-1710-1-221

Bill for family planning laboratory procedures with a type of service A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

Q0111	81000	81001	81002	81003	81025
83020	83520	84703	85014	85018	85660
86592	86593	86687	86701	87075	87081
87088	87210	87390	87470	87490	87536
87590					

262.442 Billing of Multi-Use and Single-Use Vials

11-1-1510-1-221

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges 96365 through 96379.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

   Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

   Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 262.441 for additional information regarding National Drug Code (NDC) billing.

TOC not required

242.100 Audiology Procedure Codes

10-10-14-221

Use the following procedure codes for audiological function tests.

View or print the procedure codes for Hearing (Audiology) services.

CPT Codes							
92507	92508	92540‡	92541‡	92542‡	92543‡	92544‡	92545‡
92550	92551	92552	92553	92555	92556	92557	92559
92560‡	92561‡	92562‡	92563‡	92564‡	92565	92567	92568
92570	92571	92572	92575	92576	92577	92579	92582
92583	92584‡	92585	92586	92587	92588	92590	92591
92594	92595	92620	92621	92626	92627	92630	92633
92700‡							

† Non-payable to a school district or ESC

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

Procedure Code	Required Modifier(s)	Description
92521	UA	⁂(Evaluation of speech fluency (e.g., stuttering, cluttering) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92522	UA	⁂(Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92523	UA	⁂(Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthria) with evaluation of language comprehension and expression (e.g., receptive and expressive language) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92524	UA	⁂(Behavioral and qualitative analysis of voice and resonance. (maximum of four 30-minute units per state fiscal year, July 1 through June 30)

Use the following procedure code for hearing screenings for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

HCPCS Procedure Code	Modifier
V5008	EP

242.110 Hearing Aid Procedure Codes

~~3-15-13~~10-1-~~22~~4

Use the following procedure codes for hearing aid equipment for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

View or print the procedure codes for Hearing (Audiology) services.

Medicaid covers up to 2 hearing aids per beneficiary each six-months. Hearing aid procedure codes may be billed electronically or on a paper claim form.

~~HCPCS Procedure Codes~~							
~~V5014*†~~	~~V5030†~~	~~V5040†~~	~~V5050†~~	~~V5060†~~	~~V5120†~~	~~V5130†~~	~~V5140†~~
~~V5170†~~	~~V5180†~~	~~V5210†~~	~~V5220†~~	~~V5267**†~~	~~V5299†~~		

*Repairs require prior authorization
**Accessories
† Non-payable to a school district or ESC

242.400 Special Billing Procedures

~~7-1-07~~10-1-~~22~~4

Requests for payment of hearing aids, accessories and repairs must be completed on Form CMS-1500 prior to being submitted to the Utilization Review Section.

The following documentation must accompany each request for a hearing aid:

A. Medical Clearance (within the last six (6) months, by an orologist or ENT specialist)

B. Audiogram (by certified audiologist) and Evaluation

All hearing aid providers must use code ~~V5014~~ (Hearing Aid Repair and Service) when billing for hearing aid repairs.

View or print the procedure codes for Hearing (Audiology) services.

Code ~~V5014~~ will require authorization prior to payment. All prior authorization requests must be submitted to the Hearing Aid Consultant, Division of Medical Services. **View or print the Division of Medical Services Hearing Aid Consultant contact information.**

Use code ~~V5267~~ when billing for hearing aid accessories.

TOC not required

242.110 Home Health Visits

~~8-1-04~~10-1-~~22~~4

View or print the procedure codes for Home Health services.

~~Procedure Codes~~	~~Modifiers~~	~~Description~~
~~T1021~~		~~Home Health Aide Visit~~
~~T1021~~	~~TE~~	~~Home Health LPN Visit, per visit~~
~~T1021~~	~~TD~~	~~Home Health RN Visit, per visit~~

242.120 Home Health Physical Therapy

~~11-1-06~~10-1-~~22~~4

View or print the procedure codes for Home Health services.

~~Procedure Code~~	~~Modifier~~	~~Description~~
~~S9131~~		~~Home Health Physical Therapy by a Qualified Licensed Physical Therapist~~
~~S9131~~	~~UB~~	~~Home Health Physical Therapy by a Qualified Physical Therapy Assistant~~

242.130 Specimen Collection

~~11-1-06~~10-1-~~22~~4

View or print the procedure codes for Home Health services.

~~Procedure Codes~~	
~~36415~~	~~P9612~~

A. Venipuncture (drawing blood to obtain a blood sample) and catheterization to collect urine specimens are excluded from the eligibility criteria for intermittent skilled nursing services under the home health benefit.

B. When venipuncture to obtain a blood sample or catheterization to collect a urine specimen is the only skilled service that is needed by the patient, that individual does not qualify for skilled services.

242.141 Epogen Injections for Renal Failure

~~10-15-09~~-~~22~~4

View or print the procedure codes for Home Health services.

~~National Codes~~
~~J0885~~

242.142 Epogen Injections for Diagnosis other than Renal Failure

~~10-15-09~~ 10-1-22

View or print the procedure codes for Home Health services.

~~National Codes~~		
~~J0881~~	~~J0882~~	~~J0886~~

242.144 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-22

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes for Home Health services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

   Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

   Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 242.143 for additional information regarding National Drug Code (NDC) billing.

242.150 Home Health Medical Supplies

~~7-1-16~~10-1-22

The following Health Care Procedural Coding System (HCPCS) codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers must use the current HCPCS Book for code descriptions.

View or print the procedure codes for Home Health services.

HCPCS Codes							
A4206	A4207	A4209	A4213	A4216	A4217	A4221	A4222
A4253*	A4256	A4259*	A4265	A4310	A4311	A4312	A4313
A4314	A4315	A4316	A4320	A4322	A4326	A4327	A4328
A4330	A4331	A4338	A4340	A4344	A4346	A4349	A4351
A4352	A4353	A4354	A4355	A4356	A4357	A4358	A4361
A4362	A4364	A4365	A4367	A4368	A4369	A4371	A4394
A4397	A4398	A4399	A4400	A4402	A4404	A4405	A4406
A4407	A4414	A4435	A4450	A4452	A4455	A4456	A4466
A4483	A4558	A4561	A4562	A4623	A4624	A4625	A4626
A4628	A4629	A4772	A4927	A5051	A5052	A5053	A5054
A5055	A5056	A5057	A5061	A5062	A5063	A5071	A5072
A5073	A5081	A5082	A5093	A5102	A5105	A5112	A5113
A5114	A5120	A5121	A5122	A5126	A5131	A6154	A6196
A6197	A6198	A6203	A6204	A6205	A6209	A6210	A6211
A6212	A6213	A6216	A6219	A6220	A6221	A6228	A6229
A6230	A6234	A6235	A6236	A6237	A6238	A6239	A6241
A6242	A6243	A6244	A6245	A6246	A6247	A6248	A6257
A6258	A6259	A6404	A6441	A6442	A6443	A6444	A6445
A6446	A6447	A6448	A6449	A6450	A6451	A6452	A6453
A6454	A6455	A6549**	A7045	A7046	A7520	A7521	A7522
A7524	A7525	B4082	B4100	E0776			

Listed below are medical supplies that require special billing or need prior authorization. These items are listed with the HCPCS codes and require modifiers. The asterisk denotes these items and the required modifiers.

A. *Home Blood Glucose Supplies – Pregnant Women Only, All Ages

Codes A4253 and A4259 must be billed either electronically or on paper with modifier NU for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the NU modifier.

B. **Gradient Compression Stocking (Jobst Stocking), All Ages

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. Before supplying the items, the Jobst stocking must be prior authorized by AFMC. **View or print form DMS-679A and instructions for completion.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stocking and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy.

HCPCS Code	M1	M2	Description
A6549			Gradient compression stocking, NOS (JOBST)

Code **A6549** must be manually priced.

Code **A6549** requires a prior authorization (PA). See Section 221.000.

Code **A4466** requires prior authorization (PA); see Section 221.000. Code **A4466** is manually priced and is covered for beneficiaries ages 0-20 years of age.

C. ***Food Thickeners, All Ages

Food thickeners **(B4100)**, including “Thick-it”, “Simple Thick”, “Thick and Easy” and “Thick and Clear” are not subjected to the medical supply benefit limit.

The modifier **NU** must be used with the code found in this section and when food thickeners are administered enterally, the modifier **“BA”** must be used in conjunction with the code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may be rounded up. When a date span is billed, the product cannot be billed until the end date of the span has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

The following HCPCS codes usage must match the Arkansas Medicaid code description and use of modifier(s).

HCPCS Code	M1	M2	Description
A4253	NU	UB	Blood glucose test or reagent strips for home glucose monitor, Per box of 25
A4351	U1		Intermittent urinary catheter, straight tip
A4352	U1		Intermittent urinary catheter, curved tip
A4353	U2		Intermittent urinary catheter, with insertion tray
A6197	UB		Alginate dressing, ea. (more than 16 sq. in. but less than 48 sq. in.)
A6210	NU		Foam dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6234	U1		Hydrocolloid dressing, ea. (16 sq. in. or less w/o adhesive)
A6238	U1		Hydrocolloid dressing, ea. 48 sq. in. or more
A6242	U1		Hydrogel dressing, greater than 16 sq. in. or less w/o adhesive
A6248	U1		Hydrogel dressing, 16 sq. in. or less w/o adhesive
A6549	NU		Gradient compression stocking, NOS (Jobst); 1unit = 1 stocking, Maximum 4 units per date of service (Requires prior authorization)
B4082	EP		Nasogastric tubing w/o stylet, ages 0-20 with EP modifier
B4100	NU		Food thickener, administered orally, per oz.

HCPCS Code	M1	M2	Description
B4100	NU	BA	Food thickener, administered enterally, per oz.

*The following HCPCS codes and modifiers are covered only for pregnant women.

HCPCS Code	M1	M2	Description (Pregnant Women Only)
A4253	NU	U1	Blood glucose test or reagent strips for home glucose monitor, per 50 strips (pregnant women only)
A4259	NU	U2	Lancets, per box of 100 (pregnant women only)

242.160 Incontinence Supplies

3-15-1510-1-221

Codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

View or print the procedure codes for Home Health services.

HCPCS Code	Required Modifier		Description
	M1	M2	
A4335	NU	UB	Incontinence supply; miscellaneous
A4554	NU		Disposable underpads, all sizes (e.g., Chux's)
T4521	NU		Adult-sized disposable incontinence product, brief/diaper, small, each
T4522	NU		Adult-sized disposable incontinence product, brief/diaper, medium, each
T4523	NU		Adult-sized disposable incontinence product, brief/diaper, large, each
T4524	NU		Adult-sized disposable incontinence product, brief/diaper, extra large, each
T4526	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each
T4527	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each
T4528	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each
T4529	EP		(Small diaper) Pediatric-sized disposable incontinence product, brief/diaper, small/medium size, each
T4529	EP	U1	(Medium diaper) Pediatric-size disposable incontinence product, brief/diaper, small/medium size, each
T4530	NU EP		Pediatric-sized disposable incontinence product, brief/diaper, large size, each

HCPCS Code	Required Modifier		Description
	M1	M2	
T4531	EP		(Small diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each
T4531	EP	U1	(Medium diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, small medium size each
T4532	NU EP		(Large diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each
T4532	NU EP	U1 U1	(Extra large diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each
T4533	NU EP		Youth-sized disposable incontinence product, brief/diaper, each
T4535	NU EP		Disposable liner/shield/guard/pad/undergarment for incontinence, each
T4535	NU EP	U1 U1	Disposable liner/shield/guard/pad/undergarment for incontinence, each
T4543	NU		Disposable incontinence product, brief/diaper, bariatric, each
T4544	NU		Adult-sized disposable incontinence product, protective underwear/pull-on, above extra large, each

Reimbursement is based on a per unit basis with one unit equaling one item (diaper or underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Provider may not bill “from” and “through” dates of services.

TOC required

216.300 Hysteroscopy for Foreign Body Removal

~~1-15-15~~10-1-~~22~~4

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Procedure code ~~58562~~ requires paper billing and clinical documentation for justification.

216.540 Family Planning Procedures

~~5-1-17~~10-1-~~22~~4

The following procedure code table lists family planning procedures payable to hospitals. These codes require a primary diagnosis of family planning on the claim.

Sterilization procedures require paper billing with DMS-615 attached. **View or print form DMS-615. View or print form DMS-615 Spanish.**

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~11976~~	~~11981~~	~~55250~~	~~55450~~	~~58300~~	~~58301~~	~~58340~~	~~58345~~
~~58600~~	~~58615~~	~~58661*~~	~~58670~~	~~58671~~	~~72190~~	~~J1050~~	~~J7297~~
~~J7298~~	~~J7300~~	~~J7301~~	~~J7303~~	~~J7307~~			

*CPT code ~~58661~~ represents a procedure to treat medical conditions as well as for elective sterilizations.

Family planning laboratory codes are found in **Section 216.550**.

216.550 Family Planning Lab Procedures

~~10~~-1-~~15~~22~~1~~

Family planning services are covered for beneficiaries in full coverage for Aid Category 61 (PW-PI). For additional information on Family Planning Services, see Sections 216.100-216.110, 216.130-216.132, 216.515, and 216.540-216.550.

Collection fees for laboratory procedures are included in the reimbursement for the laboratory procedure.

The following procedure codes table lists payable family planning laboratory procedure codes that require a primary diagnosis of Family Planning on the claim form:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~Family Planning Laboratory Codes~~							
~~Q0111~~	~~81000~~	~~81001~~	~~81002~~	~~81003~~	~~81025~~	~~83020~~	~~83520~~
~~84703~~	~~85014~~	~~85018~~	~~85660~~	~~86592~~	~~86593~~	~~86687~~	~~86701~~
~~87075~~	~~87081~~	~~87088~~	~~87210~~	~~87390~~	~~87470~~	~~87490~~	~~87491~~
~~87531~~	~~87536~~	~~87590~~	~~87591~~	~~87621~~	~~88142*~~	~~88143*~~	~~88147~~
~~88148~~	~~88150~~	~~88152~~	~~88153~~	~~88154~~	~~88155~~	~~88164~~	~~88165~~
~~88166~~	~~88167~~	~~88174~~	~~88175~~	~~88302~~	~~89300~~	~~89310~~	~~89320~~
~~87389~~							

*Procedure codes ~~88142 and 88143~~ are limited to one unit per beneficiary per state fiscal year.

217.062 Corneal Transplants

~~1-15-15~~10-1-221

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

C. For processing, preserving and transporting corneal tissues, use procedure code ~~V2785~~. ~~V2785 r~~Requires paper billing and a manufacturer's invoice attached to the claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

217.090 Bilaminate Graft or Skin Substitute Coverage Restriction

~~10~~-1-~~15~~221

A. Indications and Documentation:

When the diagnosis is a burn injury (**View ICD Codes.**) (indicated on the claim form), no additional medical treatment documentation is required.

This modality/product will be covered for other restricted diagnoses (indicated below) when all of the following provisions are met and are documented in the beneficiary's medical record:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of more than three (3) months duration and
3. Ulcers that have failed to respond to documented conservative measures of more than two (2) months duration.
4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment.
5. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.
6. The ulcer must be free of infection and underlying osteomyelitis; treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

Coverage of the bilaminate skin product and its application is restricted to the diagnosis represented by the following ICD codes:

(**View ICD Codes**.)

C. Outpatient Billing:

The manufactured viable bilaminate graft or skin substitute product is manually priced. It must be billed to Medicaid by paper claim with procedure code ~~J7340~~. The manufacturer's invoice, the wound size description and the operative report must be attached.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Outpatient procedures to apply bilaminate skin substitute are payable using the appropriate procedure code(s). These codes must be listed separately when filing claims and may be billed electronically.

217.113 Gastrointestinal Tract Imaging with Endoscopy Capsule

~~10~~-1-~~15~~221

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

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

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

C. Documentation of medical necessity requires a primary diagnosis of one of the following ICD diagnosis codes: (**View ICD Codes**.)

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

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

F. See **Section 272.405** for procedure code and billing instructions

217.141 Computed Tomographic Colonography (CT Colonography)

~~10~~-1-~~15~~221

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~74261~~	~~74262~~	~~74263~~

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D and/or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy), and air insufflation to achieve colonic distention.

2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to an obstruction neoplasm, spasm, redundant colon, diverticulitis extrinsic compression or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon proximal to the obstruction would be of use to the surgeons in planning the operative approach to the patient.

3. Limitations:

   a. Virtual colonography is not reimbursable when used for screening or in the absence of signs of symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.

   b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening or in the absence of signs or symptoms of disease.

   c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (e.g., biopsy) or for treatment (e.g., polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.

   d. CT colonography procedure codes are counted against the beneficiary's annual lab and X- Ray benefit limit.

   e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.

   f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD codes coded to the highest level of specificity will be denied.

2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography), which was incomplete, must be retained in the patient's record.

3. The patient's medical record must include the following and be available upon request:

   a. The order/prescription from the referring physician

   b. Description of polyps/lesion:

      i. Lesion size, for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views. The type of view employed for measurement should be stated.

      ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon, and cecum)

      iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa)

      iv. Attenuation (soft-tissue attenuation or fat)

   c. Global assessment of the colon (C-RADS categories of colorectal findings):

      i. C0 – Inadequate study

poor prep (can't exclude > 10 lesions)

ii. C1 – Normal colon or benign lesions
no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum)

iii. C2 – Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings

iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number

v. C4 – Colonic mass, likely malignant

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 – Inadequate Study limited by artifact

ii. E1 – Normal exam or anatomic variant

iii. E2 – Clinically unimportant findings (no work-up needed)

iv. E3 – Likely unimportant findings (may need work-up)
incompletely characterized lesions
(e.g.) hypodense renal or liver lesion

v. E4 – Clinically important findings (work-up needed)
(e.g.) solid renal or liver mass, aortic aneurysm, adenopathy

e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy which was incomplete due to obstruction.

244.000 Procedures that Require Prior Authorization

~~11-1-17~~10-1-~~22~~4

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. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

J7330	S2066	S2067	S2112	S3800	21199	37241	37242
37243	37244	81161	81200	81201	81202	81203	81205
81206	81207	81208	81209	81210	81211	81212	81213
81214	81215	81216	81217	81220	81221	81222	81223
81224	81225	81226	81227	81228	81229	81235	81240
81241	81242	81243	81244	81245	81250	81251	81252
81253	81254	81255	81256	81257	81260	81261	81262
81263	81264	81265	81266	81267	81268	81270	81275
81280	81281	81282	81290	81291	81292	81293	81294
81295	81296	81297	81298	81299	81300	81301	81302
81303	81304	81310	81315	81316	81317	81318	81319
81321	81322	81323	81324	81325	81326	81330	81331
81332	81340	81341	81342	81350	81355	81370	81371
81372	81373	81374	81375	81376	81377	81378	81379
81380	81381	81382	81383	81400	81401	81402	81403
81404	81405	81406	81407	81408	92607	92608	93980

B. For inpatient hospital facility abortion claims, the provider claim must use the following codes:

1. 10A00ZZ Abortion of Products of Conception, Open Approach
2. 10A03ZZ Abortion Products of Conception, Percutaneous Approach
3. 10AO7Z6 Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
4. 10A07ZW Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
5. 10A07ZX Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
6. 10A07ZZ Abortion of Products of Conception, Via Natural or Artificial Opening

C. The following outpatient hospital abortion procedure codes will require PA:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

59840	59841

245.031 Prior Authorization of Hyaluronon (Sodium Hyaluronate) Injection

~~1-15-1510-1-221~~

Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~J7321~~	~~J7323~~	~~J7324~~	~~J7325~~

A written request must be submitted to Division of Medical Services Utilization Review Section.
View or print the Division of Medical Services Utilization Review Section address.

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

252.117 Reimbursement of Burn Dressing Changes in Outpatient Hospitals

~~10-13-03-~~221

A. The CPT procedure codes for burn dressing changes are in the range of surgical procedures, but the Arkansas Medicaid Program has deemed them therapy procedures for reimbursement purposes. They are not listed in the outpatient surgical groupings.

B. Burn dressing changes are reimbursed at a global fee. The global fee includes:

1. All medication, pre-medication, I.V. fluids, dressing solutions and topical applications,
2. All dressings and necessary supplies and
3. All room charges.

C. Conform to the following procedure code definitions when billing for burn dressing changes:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~Procedure Code~~	~~Percent of Body Involvement~~
~~16020~~	~~5 to 20%~~
~~16025~~	~~21 to 40%~~
~~16030~~	~~41 to 70%~~

D. Medicaid allows reimbursement for only one burn dressing change procedure per day.

E. Physical therapy charges are not included in the global fee.

1. Physical therapy requires a written prescription by the attending physician.
2. Physical therapy requires a PCP referral.
3. A copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

272.115 Observation Bed Billing Information

~~11-1-17~~10-1-22~~1~~

Use code 760* to bill for Observation Bed. One unit of service on the CMS-1450 (UB-04) outpatient claim equals 1 hour of service. Medicaid will cover up to 8 hours of hospital observation per date of service.

When a physician admits a patient to observation subsequent to providing emergency or non-emergency services in the emergency department, the hospital may bill the observation bed code 760* and the appropriate procedure code for emergency room 450* ~~(Z0646)~~ or non-emergency room 459*. Condition code 88 must be billed to indicate an emergency claim.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

You may not bill 622* or 250*:

A. Alone or in conjunction with only one another.

B. With the non-emergency room procedure code 459*.

C. With an outpatient surgical procedure.

D. Without code 450*.

*Revenue code

272.131 Non-Emergency Charges

~~1-15-15~~10-1-22~~1~~

The following procedure codes may be billed in conjunction with procedure code 459* (“Other non-emergency service”, which includes room charge). See Section 272.510 for billing requirements.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~94010-94770~~	~~94642~~	~~96913~~	~~99199~~	~~J1100-J1200*~~
~~J1600*~~	~~J2790*~~	~~J2910*~~	~~J3420*~~	~~J9000-J9999*~~

*Refer to Section 272.510 for additional criteria.

NOTE: Arkansas Medicaid reimburses for medically necessary vaccines, laboratory services, X-Rays and machine tests in addition to standalone revenue code 0459.

272.132 Procedure Codes Requiring Modifiers

~~12-5-05~~10-1-22~~1~~

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~Procedure Code~~	~~Modifier~~	~~Description~~
~~T1015~~	~~U1~~	~~Outpatient Hospital Clinic Room Charge. This room charge includes supplies and non-physician staffing.~~
~~92507~~	~~UB~~	~~Individual Speech Therapy by SLPA~~
~~92508~~	~~UB~~	~~Group Speech Therapy by SLPA~~

~~Procedure Code~~	~~Modifier~~	~~Description~~
~~97110~~	~~UB~~	~~Individual Physical Therapy by Physical Therapy Assistant~~
~~97150~~	~~U1, UB~~	~~Group Occupational Therapy by Occupational Therapy Assistant~~
~~97150~~	~~UB~~	~~Group Physical Therapy by Physical Therapy Assistant~~
~~97530~~	~~UB~~	~~Individual Occupational Therapy by Occupational Therapy Assistant~~
~~99401~~	~~UA~~	~~Outpatient Hospital Clinic Room Charge—Periodic Family Planning Visit~~
~~99402~~	~~UA~~	~~Outpatient Hospital Clinic Room Charge—Basic Family Planning Visit~~

272.404 Hyperbaric Oxygen Therapy (HBOT) Procedures

~~10~~-1-~~09~~221

A. **Facilities may bill for only one unit of service per day.** The facility's charge for each service date must include all its hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

B. Facilities may bill for laboratory, X-ray, machine tests and outpatient surgery in addition to procedure code ~~99183~~.

C. Hospitals and ambulatory surgical centers may bill electronically or file paper claims for procedure code ~~99183~~ with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed~~—~~.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~Procedure Code~~	~~Description~~
~~99183~~	~~Hyperbaric oxygen pressurization, facility charge, one per day, outpatient~~

Refer to Sections 217.130, 242.000, 244.000, 245.030, and 252.119 for additional information on HBOT.

272.405 Billing of Gastrointestinal Tract Imaging with Endoscopy Capsule

~~10~~-1-~~15~~221

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as ~~91110~~, is payable for all ages and must be billed by using the primary diagnosis of (View ICD Codes.).

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

This procedure code should be billed with no modifiers when performed in the outpatient hospital place of service.

CPT code ~~91110~~ is payable on electronic and paper claims. For coverage policy, see Section 217.113.

272.421 Dialysis Procedure Codes

~~11-1-17~~10-1-221

The facility providing the hemodialysis and peritoneal dialysis service must use the following HCPCS procedure codes when billing for the dialysis treatment:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

The codes listed in CPT-4 must not be used.

National Code	Revenue Code Description
820*	Facility Fee-Hemodialysis (maximum - 3 treatments per week)
830*	Facility Fee - Peritoneal Dialysis (10-19 hours per week)
839*	Facility Fee - Peritoneal Dialysis (20-29 hours per week)
831*	Facility Fee - Peritoneal Dialysis (Weekly - Over 29 hours)

*Revenue code

272.435 Tissue Typing

~~3-15-05~~10-1-~~22~~4

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

A. CPT procedure codes ~~86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821 and 86822~~ are payable for the tissue typing for both the donor and the receiver.

B. The tissue typing is subject to the $500.00 annual lab and X-ray benefit limit.

1. Extensions will be considered for beneficiaries who exceed the $500.00 annual lab and X-ray benefit limit.
2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue-typing lab procedures to determine a match for an unrelated bone marrow donor.

272.436 Billing for Corneal Transplant

~~1-15-15~~10-1-~~22~~4

For processing, preserving and transporting corneal tissue, use procedure code ~~V2785. V2785~~ r

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Requires paper billing and a manufacturer's invoice attached to the claim. See Section 217.062 for coverage information.

272.437 Vascular Embolization and Occlusion

~~1-15-15~~10-1-~~22~~4

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~37241~~	~~37242~~	~~37243~~	~~37244~~

272.440 Factor VIIa

10-1-~~15~~22~~1~~

Arkansas Medicaid covers Factor VIIa (coagulation factor, recombinant) for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Factor VIIa coverage is restricted to diagnosis codes: (**View ICD Codes**.).

Providers must bill Medicaid for Factor VIIa with HCPCS procedure code ~~Q0187~~. One unit equals 1.2 milligrams.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.441 Factor VIII

~~11-1-17~~10-1-22~~1~~

HCPCS procedure code ~~J7190~~ must be used when billing for all anti-hemophiliac Factor VIII, including Monoclate.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.442 Factor IX

~~11-1-17~~10-1-22~~1~~

HCPCS procedure code ~~J7194~~ must be used when billing for Factor IX Complex (Human).

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Factor IX Complex (Human) is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.443 Factor VIII and Factor IX

~~11-1-17~~10-1-22~~1~~

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician's office or in the patient's home. The following procedure codes must be used:

~~J7191~~ Factor VIII [antihemophilic factor (porcine)], per IU

~~J7192~~ Factor VIII [antihemophilic factor (recombinant)], per IU

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code ~~**J7194**~~ must be used when billing for Factor IX Complex (human). Factor IX Complex (human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

For the purposes of Factor VIII and Factor IX coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

272.447 Bone Stimulation

10-13-03-221

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Procedure codes 20974 and 20975 are payable when provided in the physician's office, ambulatory surgical center or outpatient hospital setting to Medicaid beneficiaries of all ages. Procedure codes 20974 and 20975 will require prior authorization and are payable only for non-union of bone. When provided in the outpatient setting, the provider must submit an invoice with the claim if providing the device.

272.448 Vascular Injection Procedures

10-13-03-221

Effective for claims with dates of service on or after December 1, 1993, in accordance with Medicare guidelines, the Arkansas Medicaid Program implemented the following policy regarding vascular injection procedures:

If a provider bills procedure code 93503 and one or all of the following procedure codes on the same date of service, the Medicaid Program will reimburse for procedure code 93503 and the other codes will be denied: 36010, 36488, 36489 and 36491.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.450 Special Billing Requirements for Laboratory and X-Ray Services

1-1-2010-1-221

The following codes have special billing requirements for laboratory and X-Ray procedures.

A. CPT and HCPCS Lab Procedure Codes with Diagnosis Restrictions

The following CPT procedure codes will be payable with a primary diagnosis as is indicated below.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Procedure Code	Required Primary Diagnosis	Special Instructions
81479	None	Requires paper billing with attachments that describe and justify the service represented by this procedure.
81500 81503	(View ICD Codes.)	18y and up. This code is restricted to female beneficiaries. Requires paper billing that describes and justifies the procedure.

Procedure Code	Required Primary Diagnosis	Special Instructions
81508 81509 81510 81511 81512	Diagnosis must indicate a **current** condition of pregnancy.	None
81599*	None	For consideration of claims with unlisted procedure codes, such as **81599**, see Section 252.111 for billing instructions on this unlisted procedure code.
82777	(**View ICD Codes**.)	18y and up
83951	(**View ICD Codes**.)	None
86386	(**View ICD Codes**.)	None
86828 86829 86830 86831 86832 86833 86834 86835	(**View ICD Codes**.)	None
87389	(**View ICD Codes**.)	None
87901	None	A maximum of 12 units per 12-month period
87903	None	A maximum of 1 unit per year
87904	None	This procedure code is an add-on code.
87906	None	A maximum of 12 units per 12-month period
88720	(**View ICD Codes**.)	None
88740	(**View ICD Codes**.)	None
88741	(**View ICD Codes**.)	None

B. Genetic Testing

~~Procedure Code~~	~~Payment Method~~
~~S3831~~	~~Manually priced with no age or diagnosis restrictions~~
~~S3840~~	
~~S3844~~	
~~S3846~~	
~~S3849~~	
~~S3850~~	
~~S3853~~	
~~S3861~~	
~~S3800~~	~~Manually priced with no age or diagnosis restrictions; requires Prior Authorization. This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD diagnosis code of: (**View ICD Codes**.) and symptoms of muscle weakness, (2) documentation of muscle testing must be provided and (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.~~ ~~(See Section 241.000 regarding procedures for obtaining prior authorization by AFMC.)~~

C.

~~Procedure Code~~	~~Description~~
~~S3620~~	~~Newborn Metabolic Screening Panel~~

Arkansas Code §20-15-302 states that all newborn infants shall be tested for certain metabolic diseases. Arkansas Medicaid shall reimburse the enrolled Arkansas Medicaid hospital provider that performs the tests required for the cost of the tests. Newborn Metabolic Screenings performed inpatient are included in the interim per diem reimbursement rate and facility cost settlement. For Newborn Metabolic Screenings performed in the outpatient setting (due to retesting or as an initial screening), Arkansas Medicaid will reimburse the hospital directly. For the screenings performed in the outpatient hospital setting, the provider will submit a claim using procedure code ~~S3620~~. All positive test results shall be sent immediately to the Arkansas Department of Health.

The list of metabolic diseases for which providers can bill under ~~S3620~~ can be found within the **Arkansas Department of Health (ADH) rules pertaining to testing of newborn infants**.

272.453 Hysterectomy for Cancer or Dysplasia

~~11-1-17~~10-1-22~~1~~

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~National Code~~	~~National Code Description~~
~~58150-UA~~	~~Total hysterectomy for cancer or severe dysplasia~~

Hospitals may use procedure code ~~58150-UA~~ when billing for a total hysterectomy procedure when the diagnosis is cancer or severe dysplasia.

Procedure code ~~58150-UA~~ does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1450. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code ~~59525~~ is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

272.461 Verteporfin (Visudyne) ~~10-1-15~~22~~1~~

Verteporfin (Visudyne), HCPCS procedure code ~~J3396~~**,** is payable to outpatient hospitals when furnished to Medicaid beneficiaries of any age when the requirements identified in Section 217.140 are met.

A. Verteporfin administration may be billed separately from the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD diagnosis codes: (**View ICD Codes**.)

C. Use anatomical modifiers to identify the eye(s) being treated.

D. ~~J3396 m~~May be billed electronically or on a paper claim

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

272.462 Billing Protocol for Computed Tomographic Colonography (CT) ~~1-15-15~~10-1-~~2~~12

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~74261~~	~~74262~~	~~74263~~

B. Billing protocol for CT colonography procedure codes ~~74261, 74262 and 74263~~:

1. CT colonography is billable electronically or on paper claims.
2. For coverage policy information, see Section 217.141 of this manual.

272.500 Influenza Virus Vaccines ~~12-18-15~~10-1-~~22~~1

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

A. Procedure code ~~90655~~, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months of age, is covered through the Vaccines for Children (VFC) program.

1. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **SL**.
3. ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or Print the Department of Health contact information.**

B. Effective for dates of service on and after October 1, 2005, Medicaid covers procedure code ~~90656~~, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

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

C. Effective for dates of service on and after October 1, 2005, procedure code ~~90660~~, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B participants, the procedure code must be billed using modifier **SL**.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code ~~90657~~, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered.

1. Modifiers **EP** and **TJ** are required.
2. For ARKids First-B beneficiaries, use modifier **SL**.

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

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

272.501 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs ~~9-1-2010-1-22~~

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~1. **J2315** – Injection, naltrexone, depot form, 1 mg~~

~~2. **J0570** – Buprenorphine implant, 74.2 mg~~

~~3. **Q9991** – Injection, buprenorphine extended release (Sublocade), less than or equal to 100 mg~~

~~4. **Q9992** – Injection, buprenorphine extended release (Sublocade), greater than 100 mg~~

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

272.510 Injections, Radiopharmaceuticals and Therapeutic Agents

~~11-1-17~~10-1-~~22~~4

Intravenous administration of therapeutic agents is payable only if provided in an outpatient setting. Therapeutic injections should only be provided by facilities that have the capacity to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Reimbursement for supplies is included in the administration fee.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Use procedure code ~~96365~~ for IV infusion therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code **0760** (for observation), up to 8 hours maximum per day. For monoclonal antibody intravenous infusion use procedure code ~~79403~~**.**

Multiple units may be billed for drug procedure codes, if appropriate. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as take home drugs.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

   Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

   Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.102 for additional information regarding National Drug Code (NDC) billing.

See Section 272.450 for special billing instructions and coverage of Radiopharmaceuticals.

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

The following is a list of injections with special instructions for coverage and billing:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
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(y) or months (m).
4. The **fourth** column indicates specific ICD-9-CM primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 241.000 for prior authorization.)

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (View ICD Codes) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

~~*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)~~
~~See Section 241.000 for prior authorization procedures.~~
~~See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.~~
~~List 003/103 diagnosis codes include: (**View ICD Codes. This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.~~

~~Procedure Code~~	~~Modifier~~	~~Age Restriction~~	~~Diagnosis~~	~~Diagnosis List~~	~~Review~~	~~PA~~
~~A9520~~	~~No~~	~~18y & up~~	~~(**View ICD Codes**.)~~	~~No~~	~~No~~	~~No~~
~~A9542*~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~
~~A9543*~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~
~~A9544*~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~
~~A9545*~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~

~~NOTE: A9542 – A9545 require the Federal Drug Administration (FDA) approved diagnosis clearly stated. Treatment failures that the patient previously experiences and the patient's history and physical examination must be submitted.~~

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A9547*	No	No	No	No	No	No
NOTE: Prior Approval is required before services associated with the use of the procedure code must be provided. To obtain Prior Approval, a copy of the patient's history and physical exam must be submitted along with a report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic.						
A9555*	No	No	No	No	No	No
NOTE: To obtain Prior Approval, a copy of the patient's history and physical exam must be submitted along with a report on what other profusion scans have been tried and are non-diagnostic and attach a copy of the manufacturer's invoice to the claim.						
A9557	No	No	(**View ICD Codes**.)	No	No	No
A9559*	No	No	(**View ICD Codes**.)	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
A9563	No	No	(**View ICD Codes**.)	No	No	No
A9575	No	2y& up	No	No	No	No
A9580*	No	No	(**View ICD Codes**.)	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
A9581	No	21y & up	No	No	No	No
A9582*	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
A9585*	No	2y & up	No	No	No	No
A9586*	No	18y & up	(**View ICD Codes**.)	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
A9604*	No	21y & up	No	003/103	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
C1841*	No	No	(**View ICD Codes**.)	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
C8931	No	No	No	No	No	No
C8932	No	No	No	No	No	No
C8934	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C8935	No	No	No	No	No	No
C8936	No	No	No	No	No	No
C9132	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.						
C9133	No	18y & up	No	No	No	No
C9248	No	No	No	No	No	No
C9254	No	18y & up	No	No	No	No
C9256	No	No	No	No	No	No
C9257*	No	21y & up	Yes	No	Yes	No
NOTE: Coverage of procedure code C9257 is for ages 21 years and above with a diagnosis code (**View ICD Codes**.). Documentation included with Prior Approval Letter request must include Fluorescein angiogram or OCT, patient screen for conditions that would contraindicate the use of **Avastin**, and documentation of patient consent.						
C9363	No	No	(**View ICD Codes**.)	No	No	No
C9441	No	18y & up	(**View ICD Codes**.) **OR** (**View ICD Codes**.)	No	No	No
NOTE: **Injectafer** is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.						
C9460	No	18y & up	No	No	No	No
NOTE: Kengreal is a P2Y12 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 P2Y12 platelet inhibitor and are not being given a glycoprotein IIB/IIIA inhibitor.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	**Modifier**	**Age Restriction**	**Diagnosis**	**Diagnosis List**	**Review**	**PA**
C9733	No	No	No	No	No	No
C9734	No	No	No	No	No	No
C9739	No	No	No	No	No	No
NOTE: Covered for males only.						
G6015	No	No	No	No	No	No
J0120	No	No	No	003/103	No	No
J0129*	No	No	(**View ICD Codes**.)	No	No	No
NOTE: 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.						
J0130	No	No	No	003/103	No	No
J0132	No	No	(**View ICD Codes**.)	No	No	No
J0133	No	No	(**View ICD Codes**.)	No	No	No
J0150	No	No	No	No	No	No
NOTE: Maximum units allowed are 4 per day.						
J0151	No	No	No	No	No	No
J0153	No	No	No	No	No	No
J0171	No	No	No	No	No	No
J0178*	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: **Eylea** should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with **Eylea** injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0180*	No	No	(**View ICD Codes**.)	No	No	No
J0190	No	No	No	003/103	No	No
J0202	No	No	No	No	No	Yes
J0205	No	No	No	003/103	No	No
J0207	No	No	No	003/103	No	No
J0210	No	No	No	003/103	No	No
J0220	No	No	No	No	No	Yes
NOTE: Evaluation by a physician with a specialty in clinical genetics documenting progress required annually.						
J0221	No	No	No	No	Yes	Yes
NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile, Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme ACE Program. The history and physical should document compliance with this program including discussion of the risks of anaphylaxis, severe allergic reactions and immune-mediated reactions according to the Black Box Warning from the FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.						
J0256	No	No	(**View ICD Codes**.)	No	No	No
J0257	No	18y & up	(**View ICD Codes**.)	No	No	No
NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1-proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to alpha 1 proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0278	No	No	No	003/103	No	No
J0280	No	No	No	003/103	No	No
J0282	No	No	No	003/103	No	No
J0285	No	No	No	003/103	No	No
J0287	No	No	No	003/103	No	No
J0288	No	No	No	003/103	No	No
J0289	No	No	No	003/103	No	No
J0290	No	No	No	003/103	No	No
J0295	No	No	No	003/103	No	No
J0300	No	No	No	003/103	No	No
J0330	No	No	No	003/103	No	No
J0348	No	No	Yes	003/103	No	No
NOTE: Procedure code J0348 is valid for any condition below, along with ICD diagnosis code: (**View ICD Codes**.) (1) End stage Renal Disease (2) AIDS or cancer or (3) Post transplant status or specify transplanted organ and transplant date.						
J0350	No	No	No	003/103	No	No
J0360	No	No	No	003/103	No	No
J0364	No	No	No	No	No	No
J0380	No	No	No	003/103	No	No
J0390	No	No	No	003/103	No	No
J0400	No	No	No	No	No	No
J0401	No	13y & up	(**View ICD Codes**.)	No	No	No
J0456	No	No	No	003/103	No	No
J0461	No	No	No	003/103	No	No
J0470	No	No	No	003/103	No	No
J0475	No	No	No	No	No	No
J0476	No	No	No	No	No	No
J0480	No	No	(**View ICD Codes**.)	No	No	No
J0485	No	18y & up	(**View ICD Codes**.)	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0490*	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.						
J0500	No	No	No	003/103	No	No
J0515	No	No	No	003/103	No	No
J0520	No	No	No	003/103	No	No
J0558	No	No	No	003/103	No	No
J0561	No	No	No	003/103	No	No
J0585	No	No	No	No	Yes	No
NOTE: Botox A is reviewed for medical necessity based on ICD diagnosis code.						
J0586	No	No	No	No	Yes	No
NOTE: This procedure code is reviewed for medical necessity based on an ICD diagnosis code billed.						
J0588	No	18y & up	No	No	Yes	No
NOTE: An ICD diagnosis code which supports medical necessity is required.						
J0592	No	No	No	003/103	No	No
J0595	No	No	No	003/103	No	No
J0596	No	13y & up	(**View ICD Codes.**)	No	No	Yes
J0597*	No	13y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: This code will be reviewed for medical necessity based on the clinical documentation submitted.						
J0600	No	No	No	003/103	No	No
J0610	No	No	No	003/103	No	No
J0620	No	No	No	003/103	No	No
J0630	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0636	No	No	(**View ICD Codes**.)	No	No	No
J0637*	No	No	No	No	Yes	No
NOTE: Procedure code J0637 is 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.						
J0638	No	4y &up	(**View ICD Codes**.)	No	No	No
J0640	No	No	No	003/103	No	No
J0641	No	No	No	No	Yes	Yes
NOTE: **Approved Only**: 1. After high methotrexate therapy in osteosarcoma **OR** 2. To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.						
J0670	No	No	No	003/103	No	No
J0690	No	No	No	003/103	No	No
J0692	No	No	No	003/103	No	No
J0694	No	No	No	003/103	No	No
J0695	No	18y & up	No	No	No	No
J0696	No	No	No	003/103	No	No
J0697	No	No	No	003/103	No	No
J0698	No	No	No	003/103	No	No
J0702	No	No	Yes	003/103	No	No
NOTE: Procedure code J0702 is covered for a valid diagnosis code from the following range (**View ICD Codes**.) for complications of pregnancy or (**View ICD Codes**.) List 003/103 for all ages.						
J0706	No	No	No	003/103	No	No
J0710	No	No	No	003/103	No	No
J0712	No	18y & up	No	No	No	No
J0713	No	No	No	003/103	No	No
J0714	No	18y & up	No	No	No	No
J0715	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0716	No	No	(**View ICD Codes**.)	No	No	No
J0717	No	No	No	No	Yes	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (Cimzia) for adult beneficiaries 18 years of age and above with:

Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms:

- Diarrhea
- Internal fistulae
- Abdominal pain
- Intestinal obstruction
- Bleeding
- Extra-intestinal manifestations
- Weight loss
- Arthritis
- Perianal disease
- Spondylitis

AND

Crohn's disease has remained active despite treatment with corticosteroids or 6-mercaptopurine/azathioprine.

OR

For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed Enbrel and Humira.

J0720	No	No	No	003/103	No	No
J0725	No	No	No	003/103	No	No
J0735	No	No	No	003/103	No	No
J0740	No	No	No	003/103	No	No
J0743	No	No	No	003/103	No	No
J0744	No	No	No	003/103	No	No
J0745	No	No	No	003/103	No	No
J0760	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0770	No	No	No	003/103	No	No
J0780	No	No	No	003/103	No	No
J0795	No	No	No	003/103	No	No
J0800	No	No	No	003/103	No	No
J0833	No	No	No	No	No	No
J0834	No	No	No	No	No	No
J0850	No	No	No	003/103	No	No
J0875	No	18y & up	No	No	No	No
J0878	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0881	No	No	Yes; see below	No	No	No

NOTE: For all patients on dialysis, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

When the beneficiary is not on dialysis, use the following ICD code. (**View ICD Codes**.)

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

Column I	Column II	
	Code	Description
Secondary Anemia (**View ICD Codes**.)	(**View ICD Codes**.)	Encounter for antineoplastic chemotherapy
	(**View ICD Codes**.)	Following chemotherapy
	(**View ICD Codes**.)	Antineoplastic and immunosuppressive drugs

Use ICD code (**View ICD Codes**.) (primary) with (**View ICD Codes**.) or (**View ICD Codes**.) (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.

Column I	Column II	
	Code	Description
Anemia of other chronic disease (**View ICD Codes**.)	(**View ICD Codes**.)	Chronic Hepatitis C without mention of coma
	(**View ICD Codes**.)	Myelodysplastic
	(**View ICD Codes**.)	Rheumatoid Arthritis

J0882	No	No	(**View ICD Codes**.)	No	No	No
J0885						

NOTE: See procedure code J0881 in this section for specific criteria.

J0886	No	No	(**View ICD Codes**.)	No	No	No
J0887	No	21y & up	Yes; see below	No	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: The primary diagnosis should be (**View ICD Codes.**) with a secondary diagnosis of (**View ICD Codes.**). For patients with CKD on dialysis: Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL. If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera. The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic. Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary						
J0894*	No	No	(**View ICD Codes.**)	No	No	No
J0895	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	Yes
NOTE: **Prolia Policy**: Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (**View ICD Codes**.). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high-risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for **Prolia**. An additional indication approved by the FDA for use of **Prolia** is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (**View ICD Codes**.) or adjuvant aromatase inhibitor therapy for breast cancer (**View ICD Codes**.). In men with non-metastatic prostate cancer, **Denosumab** also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why **Zometa** cannot be used. The NDC for the drug requested must be listed on the request. **Xgeva Policy**: Arkansas Medicaid requires that **Xgeva** be filed under J0897 on a paper claim with the drug name and dose. **Xgeva** is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. **Xgeva** is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. **Xgeva** requires documentation in the medical record of the rationale for why **Zometa** was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record. The NDC for the drug requested must be listed on the request.						
J0945	No	No	No	003/103	No	No
J1000	No	No	No	003/103	No	No
J1020	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1030	No	No	No	003/103	No	No
J1040	No	No	No	003/103	No	No
J1050	FP	10y & up	No	No	No	No
^ J1050 is covered for therapeutic and family planning services for females only. For therapeutic use, a diagnosis and clinical records must justify the treatment. When billed for family planning, a FP modifier and an ICD family planning diagnosis is required.						
NOTE: Relative to post occlusion by placement of permanent implants; procedure codes J1050, 11976 and 58301 are payable family planning services for non-sterile females only. All visits related to post 58565 services during the six (6) months following the procedure are included in the allowable fee for the 58565 "procedure." All facility fees for J1050 are bundled under the surgical procedure code if performed on the same date of service.						
J1050	No	10y & up	No	No	No	No
^ J1050 is covered for therapeutic and family planning services for females only. For therapeutic use, a diagnosis and clinical records must justify the treatment. When billed for family planning, a FP modifier and an ICD family planning diagnosis is required.						
NOTE: Relative to post occlusion by placement of permanent implants; procedure codes J1050, 11976 and 58301 are payable family planning services for non-sterile females only. All visits related to post 58565 services during the six (6) months following the procedure are included in the allowable fee for the 58565 "procedure." All facility fees for J1050 are bundled under the surgical procedure code if performed on the same date of service.						
J1071	No	No	No	003/103	No	No
J1080	No	No	No	003/103	No	No
J1094	No	No	No	003/103	No	No
J1100	No	No	Yes	003/103	No	No
NOTE: Procedure code J1100 is covered for a valid diagnosis code (**View ICD Codes**.) for complications of pregnancy or (**View ICD Codes**.) List 003/103 for all ages.						
J1110	No	No	No	003/103	No	No
J1120	No	No	No	003/103	No	No
J1160	No	No	No	003/103	No	No
J1162	No	No	(**View ICD Codes**.)	No	No	No
J1165	No	No	No	003/103	No	No
J1170	No	No	No	003/103	No	No
J1180	No	No	No	003/103	No	No
J1190	No	No	No	003/103	No	No
J1200	No	No	No	003/103	No	No
J1205	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1212	No	No	No	003/103	No	No
J1230	No	No	No	003/103	No	No
J1240	No	No	No	003/103	No	No
J1245	No	No	No	003/103	No	No
J1250	No	No	No	003/103	No	No
J1260	No	No	No	003/103	No	No
J1265	No	No	No	No	No	No
J1267	No	No	No	003/103	No	No
J1270	No	No	No	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below :

- A valid ICD diagnosis from list 003/103 (**View ICD Codes**.) or a valid ICD code of renal failure code. (**View ICD Codes**.)
- **Plus** an ICD diagnosis from the following code range. (**View ICD Codes**.)
- **Plus** an ICD diagnosis of (**View ICD Codes**.).

J1290*	No	16y & up	(**View ICD Codes**.)	No	Yes	No
J1300	No	No	(**View ICD Codes**.)	No	No	Yes
J1320	No	No	No	003/103	No	No
J1324	No	No	No	No	No	No
J1325	No	No	No	003/103	No	No
J1327	No	No	No	003/103	No	No
J1330	No	No	No	003/103	No	No
J1335	No	No	No	003/103	No	No
J1364	No	No	No	003/103	No	No
J1380	No	No	No	003/103	No	No
J1410	No	No	No	003/103	No	No
J1435	No	No	No	003/103	No	No
J1436	No	No	No	003/103	No	No
J1439	No	18y & up	(**View ICD Codes**.)	No	No	No
J1442	No	No	No	No	No	No
J1443	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1447	No	No	No	No	No	Yes
J1450	No	No	No	003/103	No	No
J1451	No	No	(**View ICD Codes**.)	No	No	No
J1452	No	No	No	003/103	No	No
J1453	No	No	No	003/103	No	No
J1455	No	No	No	003/103	No	No
J1457	No	No	No	003/103	No	No
J1458*	No	No	(**View ICD Codes**.)	No	Yes	No
J1459	No	16y & up	No	No	No	No
J1460	No	No	No	No	No	No
J1556*	No	6y & up	No	No	Yes	Yes
NOTE: **Bivigam** is an immune globulin intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.						
J1557	No	2y & up	No	No	Yes	No
NOTE: An ICD diagnosis code that supports medical necessity is required.						
J1559	No	4y & up	(**View ICD Codes**.)	No	No	No
J1560	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1566	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1568	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1569	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1570	No	No	No	003/103	No	No
J1571	No	No	No	No	No	No
J1572	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1573	No	No	No	No	No	No
J1575	No	18y & up	No	No	No	Yes
J1580	No	No	No	003/103	No	No
J1590	No	No	No	003/103	No	No
J1599*	No	4y & up	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1600	No	No	No	No	No	No
J1602*	No	18y & up	No	No	Yes	Yes
NOTE: **Simponi** is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with: 1. Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**. 2. Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**. 3. Active ankylosing spondylitis that has failed **Humira** and **Enbrel**. 4. Moderate to severe ulcerative colitis that has failed **Humira**. Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.						
J1610	No	No	No	003/103	No	No
J1620	No	No	No	003/103	No	No
J1626	No	No	No	003/103	No	No
J1630	No	No	No	003/103	No	No
J1631	No	No	No	003/103	No	No
J1640	No	No	(**View ICD Codes**.)	No	No	No
J1642	No	No	No	003/103	No	No
J1644	No	No	No	003/103	No	No
J1645	No	No	No	003/103	No	No
J1650	No	No	No	No	No	No
J1652	No	No	No	No	No	No
J1655	No	No	No	003/103	No	No
J1670	No	No	No	003/103	No	No
J1700	No	No	No	003/103	No	No
J1710	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1720	No	No	No	003/103	No	No
J1725	No	16y & up	(**View ICD Codes**.)	No	No	No
NOTE: Arkansas Medicaid will reimburse providers for **17-Hydroxyprogesterone Caproate**, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (**View ICD Codes**.), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for **17-Hydroxyprogesterone Caproate** is included in the reimbursement fee allowed for this drug.						
J1730	No	No	No	003/103	No	No
J1740	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No
J1742	No	No	No	003/103	No	No
J1743	No	No	No	No	No	Yes
NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1745	No	No	No	No	Yes	Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis **is** (**View ICD Codes**.). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 year require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

ICD diagnosis code (**View ICD Codes**.) as the primary detail diagnosis **AND** a secondary diagnosis of (**View ICD Codes**.)

OR

ICD diagnosis code range (**View ICD Codes**.)

OR

ICD diagnosis code (**View ICD Codes**.)

OR

ICD diagnosis code (**View ICD Codes**.)

ICD diagnosis code (**View ICD Codes**.) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

OR

ICD diagnosis code (**View ICD Codes**.)

ICD diagnosis code (**View ICD Codes**.)requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No	No
J1756	No	18y & up	No	No	Yes	Yes
J1786	No	2y & up	No	No	No	Yes
J1790	No	No	No	003/103	No	No
J1800	No	No	No	003/103	No	No
J1810	No	No	No	003/103	No	No
J1815	No	No	No	003/103	No	No
J1830	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1833	No	18y & up	No	No	No	No
J1835	No	No	No	003/103	No	No
J1840	No	No	No	003/103	No	No
J1850	No	No	No	003/103	No	No
J1885	No	No	No	003/103	No	No
J1890	No	No	No	003/103	No	No
J1930	No	No	No	No	No	No
J1931	No	No	(**View ICD Codes**.)	No	Yes	Yes
J1940	No	No	No	003/103	No	No
J1945	No	No	(**View ICD Codes**.)	No	No	No
J1950	No	No	No	003/103	No	No
J1953	No	17y & up	No	No	No	No
J1955	No	No	No	003/103	No	No
J1956	No	No	No	003/103	No	No
J1960	No	No	No	003/103	No	No
J1980	No	No	No	003/103	No	No
J1990	No	No	No	003/103	No	No
J2001	No	No	No	003/103	No	No
J2010	No	No	No	003/103	No	No
J2020	No	No	No	003/103	No	No
J2060	No	No	No	003/103	No	No
J2150	No	No	No	003/103	No	No
J2175	No	No	No	003/103	No	No
J2180	No	No	No	003/103	No	No
J2185	No	No	No	003/103	No	No
J2210	No	No	No	003/103	No	No
J2248	No	No	No	No	No	No
J2250	No	No	No	003/103	No	No
J2260	No	No	(**View ICD Codes**.)	No	No	No
J2270	No	No	No	003/103	No	No
J2271	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2274	No	No	No	No	No	No
J2275	No	No	No	003/103	No	No
J2278	No	No	No	003/103	No	No
J2280	No	No	No	003/103	No	No
J2300	No	No	No	003/103	No	No
J2310	No	No	No	003/103	No	No
J2320	No	No	No	003/103	No	No
J2323	No	No	No	No	Yes	No
NOTE: The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the Prior Approval Letter.						
J2325	No	No	(**View ICD Codes**.)	No	No	No
J2353*	No	No	No	003/103	Yes	Yes
J2354*	No	No	No	003/103	Yes	Yes
NOTE: A Prior Approval Letter is required for a diagnosis other than a List 003/103 diagnosis.						
J2355	No	No	No	003/103	No	No
J2358	No	18y &up	No	003/103	No	No
J2360	No	No	No	003/103	No	No
J2370	No	No	No	003/103	No	No
J2400	No	No	No	003/103	No	No
J2405	No	No	No	003/103	No	No
J2407	No	18y & up	No	No	No	No
J2410	No	No	No	003/103	No	No
J2425	No	No	No	003/103	No	No
J2426	No	18y & up	(**View ICD Codes**.)	No	No	No
J2430	No	No	No	003/103	No	No
J2440	No	No	No	003/103	No	No
J2460	No	No	No	003/103	No	No
J2469	No	No	No	003/103	No	No
J2501	No	No	No	No	No	No
J2503	No	No	(**View ICD Codes**.)	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2504	No	No	(**View ICD Codes**.)	No	No	No
J2505	No	No	Yes	003/103	Yes	No
NOTE: Procedure code J2505 is payable for beneficiaries of all ages with a detail diagnosis code (**View ICD Codes.**). Diagnosis codes (**View ICD Codes.**) are covered along with a diagnosis of AIDS or cancer (List 003/103). Diagnosis codes must be shown on the claim form.						
J2507	No	18y & up	No	No	Yes	Yes
NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.						
J2510	No	No	No	003/103	No	No
J2513	No	No	No	No	No	No
J2515	No	No	No	003/103	No	No
J2540	No	No	No	003/103	No	No
J2543	No	No	No	003/103	No	No
J2547	No	18y & up	(**View ICD Codes**.)	No	No	No
J2550	No	No	No	003/103	No	No
J2560	No	No	No	003/103	No	No
J2562	No	21y & up	No	No	No	Yes
NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). Prior authorization will be provided by a telephone review. Approval is granted in conjunction with the use of granulocyte-colony stimulating factor to mobilize hematopoietic stem cells for collection and subsequent autologous transplantation in patients with Non-Hodgkin's lymphoma and multiple myeloma. Applicants will only be considered for approval if a transplant has been approved by AFMC. There must be documentation of failure to mobilize cells with conventional therapy for consideration of this drug. The drug will only be approved for four doses; one daily, times four days. The total dosage for the four days must be indicated at the time of the request.						
J2590	No	No	No	003/103	No	No
J2597	No	No	No	No	No	No
J2650	No	No	No	003/103	No	No
J2670	No	No	No	003/103	No	No
J2675	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2680	No	No	No	003/103	No	No
J2690	No	No	No	003/103	No	No
J2700	No	No	No	003/103	No	No
J2710	No	No	No	003/103	No	No
J2720	No	No	No	003/103	No	No
J2724	No	No	No	No	No	No
J2725	No	No	No	003/103	No	No
J2730	No	No	No	003/103	No	No
J2760	No	No	No	003/103	No	No
J2765	No	No	No	003/103	No	No
J2770	No	No	No	003/103	No	No
J2778	No	No	No	No	Yes	Yes
J2780	No	No	No	003/103	No	No
J2783	No	No	No	003/103	No	No
J2788	No	No	No	No	No	No
J2790	No	No	No	No	No	No
J2791	No	No	No	No	No	No
J2792	No	No	No	No	No	No
J2796	No	19y & up	(**View ICD Codes**.)	No	No	No

NOTE: Beneficiaries must have failed corticosteroids, immunoglobulins or have had a splenectomy. Beneficiaries must have thrombocytopenia and a clinical condition that causes increased risk of bleeding.

Romiplostim is not to be used to normalize platelet counts.

J2800	No	No	No	003/103	No	No
J2820	No	No	No	003/103	No	No
J2860	No	No	No	No	No	No
J2910	No	No	(**View ICD Codes**.)	No	No	No
J2916	No	No	No	No	No	No
J2920	No	No	No	003/103	No	No
J2930	No	No	No	003/103	No	No
J2941	No	No	No	003/103	No	No
J2950	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2993	No	No	No	No	No	No
NOTE: For the purpose of declotting catheters, bill diagnosis (**View ICD Codes**.) on the claim.						
J2995	No	No	No	003/103	No	No
J2997	No	No	No	No	No	No
NOTE: For the purpose of declotting catheters, bill diagnosis (**View ICD Codes**.) on the claim.						
J3000	No	No	No	003/103	No	No
J3010	No	No	No	003/103	No	No
J3030	No	No	No	003/103	No	No
J3060*	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A complete history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.						
J3070	No	No	No	003/103	No	No
J3095	No	18y & up	No	003/103	No	No
J3101	No	21y & up	(**View ICD Codes**.)	003/103	Yes	No
NOTE: Ages 0-20 years have no restrictions.						
J3105	No	No	No	003/103	No	No
J3120	No	No	No	003/103	No	No
J3121	No	No	No	003/103	No	No
NOTE: Covered for males only.						
J3130	No	No	No	003/103	No	No
J3145	No	No	No	003/103	No	No
NOTE: Covered for males only.						
J3230	No	No	No	003/103	No	No
J3240	No	No	No	003/103	No	No
J3243	No	No	No	No	No	No
J3246	No	No	No	No	No	No
J3250	No	No	No	003/103	No	No
J3260	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3262	No	18y & up	No	No	Yes	Yes
NOTE: The patient must have tried and failed therapy with documented progression of symptoms on **Humira** and **Enbrel** prior to the request for this drug. The physician medical record must document a history and physical examination that clearly shows failure of **Humira** and **Enbrel** with submission for a prior approval letter. Doses exceeding 800 mg per infusion will not be approved, as they are not recommended. The physician must follow all Food and Drug Administration (FDA) recommendations on monitoring of laboratory and serious infections.						
J3265	No	No	No	003/103	No	No
J3280	No	No	No	003/103	No	No
J3285	No	No	(**View ICD Codes**.)	No	No	No
J3300	No	No	No	No	No	No
J3301	No	No	No	003/103	No	No
J3302	No	No	No	003/103	No	No
J3303	No	No	No	003/103	No	No
J3305	No	No	No	003/103	No	No
J3310	No	No	No	003/103	No	No
J3315	No	No	No	003/103	No	No
J3320	No	No	No	003/103	No	No
J3350	No	No	No	003/103	No	No
J3357*	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: There must be clear documentation that the patient has failed **Humira** and **Enbrel**, with documentation of progression of the disease or documented inability to tolerate **Humira** and **Enbrel**. A physician history and physical must be submitted with a request for prior approval letter. Documentation of patient counseling of the adverse effects of the drug should also be included. This drug should only be administered to patients who will be closely monitored and have regular follow-up visits by a physician.						
J3360	No	No	No	003/103	No	No
J3364	No	No	No	003/103	No	No
J3365	No	No	No	003/103	No	No
J3370	No	No	No	003/103	No	No
J3380	No	18y – 99y	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3385*	No	No	No	No	Yes	Yes
NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. A history and physical exam by a geneticist is required yearly for approval. The history and physical exam should document the prognosis of the patient as well as current symptoms.						
J3396	No	No	(**View ICD Codes**.)	No	Yes	No
J3400	No	No	No	003/103	No	No
J3410	No	No	No	003/103	No	No
J3420	No	No	(**View ICD Codes**.)	No	No	No
J3430	No	No	No	003/103	No	No
J3465	No	No	No	No	No	No
NOTE: Procedure code J3465 is covered for non-pregnant beneficiaries.						
J3470	No	No	No	003/103	No	No
J3473	No	No	No	No	No	No
J3475	No	No	No	003/103	No	No
J3480	No	No	No	003/103	No	No
J3485	No	No	No	003/103	No	No
J3489	No	No	(**View ICD Codes**.)	No	No	No
J3490*	No	No	No	003/103	No	No
NOTE: Requires a paper claim form with the name of the drug, dosage and the route of administration for consideration for eligible beneficiaries. Clinical documentation may be required. See Section 252.111 for additional billing information.						
J3490	U9	16y & up	(**View ICD Codes**.)	No	No	No
NOTE: Arkansas Medicaid will reimburse providers for "**Compounded 17-Hydroxyprogesterone Caproate**, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "**Compounded 17-Hydroxyprogesterone Caproate** 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of V23.41, "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "**Compounded 17-Hydroxyprogesterone Caproate**, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "**Compounded 17-Hydroxyprogesterone Caproate** 250 mg."						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3520	No	No	No	003/103	No	No
J7121	No	No	No	No	No	No
J7178	No	No	(**View ICD Codes**.)	No	No	No
J7180	No	2y & up	(**View ICD Codes**.)	No	No	No
J7181	No	No	(**View ICD Codes.**)	No	No	No
J7183	No	No	(**View ICD Codes**.)	No	No	No
J7185	No	21y – 65y	No	No	No	No
J7186	No	No	No	No	No	No
J7187	No	No	No	No	No	No
J7188	No	18y & up	No	No	No	Yes
J7189	No	No	No	No	No	No
J7190	No	No	No	No	No	No
J7191	No	No	No	No	No	No
J7192	No	No	No	No	No	No
J7193	No	No	No	No	No	No
J7194	No	No	No	No	No	No
J7195	No	No	No	No	No	No
J7196	No	18y & up	(**View ICD Codes**.)	No	No	No
J7197	No	No	No	No	No	No
J7198	No	No	No	No	No	No
J7199*	No	No	No	No	No	No
NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration. See Section 252.111 for billing instructions.						
J7297*	FP	12y – 65y	No	No	No	No
NOTE: J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7298*	FP	12y – 65y	No	No	No	No
NOTE: J7297 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7298*		12y – 65y	No	No	No	No
J7300	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7301	No	No	No	No	No	No
J7303	FP	No	No	No	No	No
J7306	No	No	No	No	No	No
J7307	FP	No	No	No	No	No
J7308	No	No	No	003/103	No	No
J7310	No	No	No	003/103	No	No
J7311*	No	No	No	No	Yes	No
J7312	No	No	No	Yes	Yes	Yes

NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method. There should be documentation of vein occlusion and studies documenting macular edema. Visual acuity should be noted after the vein occlusion or after failed treatments for uveitis. The patients should be monitored after the injection for elevation in intraocular pressure and endophthalmitis. Counseling of side effects should be documented in the medical record. The history and physical exam including all tests should be sent with the request for prior approval letter.

J7313	No	18y & up	No	No	No	Yes
J7316	No	18y & up	No	No	Yes	No

NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.

J7321	No	No	No	No	No	Yes
J7323	No	No	No	No	No	Yes
J7324	No	No	No	No	No	Yes
J7325	No	No	No	No	No	Yes

NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection for outpatient hospital providers. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. **Hyaluronon** is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections per knee are allowed of **Hylan** polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures. Refer to Section 245.031 for Prior Authorization.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7327	No	18y & up	No	No	No	No
J7328	No	22y & up	No	No	No	No
J7330	No	No	No	No	No	Yes
NOTE: Procedure code J7330 requires prior authorization from AFMC for all providers. See Section 241.000 for more information on obtaining prior authorization from AFMC.						
J7501	No	No	No	003/103	No	No
J7502	No	No	No	No	No	No
J7504	No	No	No	003/103	No	No
J7505	No	No	No	003/103	No	No
J7506	No	No	No	003/103	No	No
J7507	No	No	No	003/103	No	No
J7508	No	No	(**View ICD Codes**.)	No	No	No
J7509	No	No	No	003/103	No	No
J7510	No	No	No	003/103	No	No
J7511	No	No	No	003/103	No	No
J7513	No	No	No	003/103	No	No
J7515	No	No	No	No	No	No
J7516	No	No	No	No	No	No
J7517	No	No	No	No	No	No
J7518	No	No	No	003/103	No	No
J7520	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No
NOTE: For consideration, procedure code J7525 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.						
J7527	No	18y & up	(**View ICD Codes**.)	No	No	No
J7599*	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 must be billed on a paper claim form with the name of the drug, dosage and the route of administration. See Section 252.111 for billing instructions.						
J8530	No	No	No	003/103	No	No
J8650	No	No	No	No	No	No
J8705	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9000	No	No	No	003/103	No	No
J9010	No	No	No	003/103	No	No
J9015	No	No	No	003/103	No	No
J9017	No	No	No	003/103	No	No
J9019*	No	2y-18y	No	No	Yes	No
J9020	No	No	No	003/103	No	No
J9025	No	No	No	No	No	Yes
J9027	No	1y to 20y	(**View ICD Codes**.)	No	No	No
J9031	No	No	No	003/103	No	No
J9032	No	18y & up	No	No	No	Yes
J9033*	No	21y & up	(**View ICD Codes**.)	No	Yes	No
J9035*	No	No	(**View ICD Codes**.)	No	Yes	No
J9039	No	18y & up	No	No	No	Yes
J9040	No	No	No	003/103	No	No
J9041	No	No	No	No	Yes	Yes
J9042	No	18y & up	No	No	Yes	Yes

NOTE: **Adcetris** – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, ICD diagnosis: (**View ICD Codes**.) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043	No	18y & up	No	No	Yes	Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with docetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9045	No	No	No	003/103	No	No
J9047	No	No	No	No	Yes	Yes
NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.						
J9050	No	No	No	003/103	No	No
J9055	No	No	No	No	Yes	Yes
J9060	No	No	No	003/103	No	No
J9065	No	No	No	003/103	No	No
J9070	No	No	No	003/103	No	No
J9098	No	No	No	003/103	Yes	No
J9100	No	No	No	003/103	No	No
J9120	No	No	No	003/103	No	No
J9130	No	No	No	003/103	No	No
J9150	No	No	No	003/103	No	No
J9151	No	No	No	003/103	No	No
J9155	No	21y & up	No	003/103	No	No
NOTE: Covered for male beneficiaries only.						
J9160	No	No	(**View ICD Codes**.) **OR** (**View ICD Codes**.)	No	Yes	No
J9165	No	No	No	003/103	No	No
J9171	No	No	No	003/103	No	No
J9178	No	No	No	No	Yes	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9179	No	No	No	No	Yes	Yes
NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.						
J9181	No	No	No	003/103	No	No
J9185	No	No	No	003/103	No	No
J9190	No	No	No	003/103	No	No
J9200	No	No	No	003/103	No	No
J9201	No	No	No	003/103	No	No
J9202	No	No	No	003/103	No	No
J9206	No	No	No	003/103	No	No
J9207	No	No	No	No	Yes	Yes
J9208	No	No	No	003/103	No	No
J9209	No	No	No	003/103	No	No
J9211	No	No	No	003/103	No	No
J9212	No	No	No	003/103	No	No
J9213	No	No	No	003/103	No	No
J9214	No	No	No	003/103	No	No
J9215	No	No	No	003/103	No	No
J9216	No	No	No	003/103	No	No
J9217	No	No	No	003/103	No	No
J9218	No	No	No	003/103	No	No
J9219	No	No	(**View ICD Codes**.) **OR** (**View ICD Codes**.)	No	No	No
NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.						
J9225	No	No	(**View ICD Codes**.)	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9226	No	No	No	No	Yes	Yes
NOTE: **Supprelin LA**: Prior to initiation of treatment, a clinical diagnosis of CPP, ICD code of: (**View ICD Codes**.), 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.						
J9228	No	No	No	No	Yes	Yes
NOTE: **Ipilimumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for **Zelboraf**. If positive for the mutation, the patient should first be given a trial of **Zelboraf**. If the patient fails the trial or does not have the mutation, then they should be considered for **Ipilimumab**. **Ipilimumab** should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of **Ipilimumab** requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with **Ipilimumab** should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.						
J9230	No	No	No	003/103	No	No
J9245	No	No	No	003/103	No	No
J9250	No	No	No	No	No	No
J9260	No	No	No	003/103	No	No
J9261	No	No	No	No	Yes	Yes
NOTE: The disease must have not responded to, or either has relapsed, following treatment with at least 2 chemotherapy regimens.						
J9262	No	No	No	No	Yes	Yes
NOTE: **Synribo** is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.						
J9263	No	No	No	No	Yes	Yes
J9264	No	No	No	No	Yes	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9265	No	No	No	003/103	No	No
J9266	No	No	No	003/103	No	No
J9268	No	No	No	003/103	No	No
J9270	No	No	No	003/103	No	No
J9271	No	18y & up	No	No	No	Yes
J9280	No	No	No	003/103	No	No
J9293	No	No	Yes	No	Yes	No
NOTE: Requires ICD diagnosis code for cancer or ICD diagnosis code of: (**View ICD Codes**.)						
J9300	No	No	No	003/103	No	No
J9301	No	No	No	No	No	Yes
J9302	No	No	No	No	No	Yes
J9303	No	No		No	Yes	Yes
J9305	No	No		No	Yes	Yes
J9306	No	No	No	No	Yes	Yes
NOTE: **Perjeta** is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with tratuzumab and docetaxol for the treatment of patients with Her2 positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.						
J9307	No	18y & up	No	003/103	No	No
J9310	No	No	No	003/103	No	No
J9315	No	18y & up	No	003/103	No	No
J9320	No	No	No	003/103	No	No
J9328	No	No	No	No	Yes	Yes
NOTE: The diagnosis must be for: • Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy **OR** • As maintenance treatment for refractory anaplastic astrocytoma in patients who have disease progression on nitrosourea and procarbazine						
J9330	No	21y & up	(**View ICD Codes**.)	No	No	No
J9340	No	No	No	003/103	No	No
J9351	No	18y & up	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9354	No	No	No	No	Yes	Yes

NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **traztuzumab** and a **taxane**, separately or in combination. Patients should have either:

1. received prior therapy for metastatic disease,

OR

2. developed disease recurrence during or within six months of completing adjuvant therapy.

All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.

J9355	No	No	No	003/103	No	No
J9357	No	No	No	003/103	No	No
J9360	No	No	No	003/103	No	No
J9370	No	No	No	003/103	No	No
J9371	No	No	No	No	Yes	Yes

NOTE: **Marqibo** is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.

J9390	No	No	No	003/103	No	No	No
J9395	No	No	No	No	Yes	Yes
J9400	No	No	No	No	Yes	Yes

NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.

J9600	No	No	No	003/103	No	No
J9999	No	No	No	003/103	Yes	No

NOTE: See Section 252.111 in this manual for coverage information.

P9041	No	No	No	No	No	No
P9045	No	No	No	No	No	No
P9046	No	No	No	No	No	No
P9047	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
Q0139	No	No	(**View ICD Codes**.)	No	No	No
Q0162	UB	4y & up	No	No	No	No
NOTE: Q0162 UB represents "Ondansetron 1 mg, oral" billable electronically or on paper.						
Q0166	UB	No	No	003/103	No	No
NOTE: Use UB modifier for Q0166 – "Granistron HCl tab 1 mg, oral" (**Kytril**). This is the Arkansas Medicaid description.						
Q2009	No	No	No	003/103	No	No
Q2017	No	No	No	003/103	No	No
Q2034	No	18y & up	No	No	No	No
Q2043*	No	18y & up	(**View ICD Codes**.)	No	Yes	No
NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.						
Q2049	No	18y & up	No	003/103	No	No
Q2050	No	No	No	003/103	No	No
Q3027	No	18y & up	(**View ICD Codes**.)	No	No	No
Q4081	No	No	(**View ICD Codes**.)	No	No	No
Q4101	No	No	No	No	No	No
Q4102	No	No	No	No	No	No
Q4103	No	No	No	No	No	No
Q4104	No	No	No	No	No	No
Q4105	No	No	No	No	No	No
Q4106	No	No	No	No	No	No
Q4107	No	No	No	No	No	No
Q4108	No	No	No	No	No	No
Q4110	No	No	No	No	No	No
Q4111	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
Q4112	No	No	No	No	Yes	No
Q4113	No	No	No	No	Yes	No
Q4114	No	No	No	No	Yes	No
Q4116	No	No	(**View ICD Codes**.)	No	No	No
Q4121	No	No	No	No	No	No
Q4124	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
Q4145*	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
Q9969	No	No	No	No	No	No
S0017	No	No	No	003/103	No	No
S0021	No	No	No	003/103	No	No
S0023	No	No	No	003/103	No	No
S0028	No	No	No	003/103	No	No
S0030	No	No	No	003/103	No	No
S0032	No	No	No	003/103	No	No
S0034	No	No	No	003/103	No	No
S0039	No	No	No	003/103	No	No
S0040	No	No	No	003/103	No	No
S0073	No	No	No	003/103	No	No
S0074	No	No	No	003/103	No	No
S0077	No	No	No	003/103	No	No
S0078	No	No	No	003/103	No	Yes
S0080	No	No	No	003/103	No	No
S0081	No	No	No	003/103	No	No
S0092	No	No	No	003/103	No	No
S0093	No	No	No	003/103	No	No
S0108	No	No	No	003/103	No	No
S0119	No	4y & up	No	No	No	No
S0145	No	No	(**View ICD Codes**.)	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
S0164	No	No	No	003/103	No	No
S0177	No	No	No	003/103	No	No
S0179	No	No	No	003/103	No	No
S0187	No	No	No	003/103	No	No
90375*	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. Attach the manufacturer's invoice along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration to the claim. Reimbursement rate includes administration fee.						
90376*	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. Attach the manufacturer's invoice along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration to the claim. Reimbursement rate includes administration fee.						
90385	No	No	No	No	No	No
NOTE: Procedure code 90385 is limited to one injection per pregnancy.						
90386	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No
NOTE: Indicate dose and attach the manufacturer's invoice to the claim.						
90632	No	19y & up	No	No	No	No
90662	No	65y & up	No	No	No	No
NOTE: Procedure code 90662 is covered for beneficiaries ages 65 years and older for dates of service on or after October 11, 2010.						
90673	No	19y-49y	No	No	No	No
90675*	No	No	No	No	No	No
NOTE: Procedure code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in claim form CMS-1450 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. Attach the manufacturer's invoice to the claim. Reimbursement rate includes administration fee.						
90676*	No	No	No	No	No	No
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in claim form CMS-1450 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. Attach the manufacturer's invoice to the claim. Reimbursement rate includes administration fee.						
90690	No	6y & up	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol.)
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 148 of this document.**) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90691	No	3y & up	No	No	No	No
90703	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No
90705	No	1y & up	No	No	No	No
90706	No	1y & up	No	No	No	No
90707	U1	21y – 44y	No	No	No	No
NOTE: Procedure code **90707** is 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.						
90707	No	19y – 20y	No	No	No	No
90708	No	9m & up	No	No	No	No
90717*	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.						
90732	No	2y & up	No	No	No	No
NOTE: 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	No	No	No	No	No	No
90735	No	0 – 20y	No	No	No	No
90736	No	60y & up	No	No	No	No
NOTE: Zoster vaccine is benefit limited to once in a lifetime.						
90740	No	No	No	No	No	No
90746	No	19y & up	No	No	No	No
96379*	No	No	No	No	No	No
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.						

TOC not required

242.110 Parenteral Hyperalimentation Services

~~11-1-17~~10-1-22~~1~~

One unit of service equals a half-liter of fluid and includes fluids and the equipment and supplies necessary for the administration of the fluids in the beneficiary's place of residence.

View or print the procedure codes for Hyperalimentation services.

~~National Procedural Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA Required~~	~~Deleted Local Code~~
~~B4220~~	~~U1~~		~~** Hyperalimentation Global Fee~~	~~Y~~	~~Z0620~~

242.120 Enteral (Sole Source) Formulae

~~12-1-20~~10-1-22~~1~~

The following pages provide the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

Modifiers in this section are indicated by the headings M1, M2, and M3.

Enteral formulae are divided into several categories. Each unit of service equals one-hundred (100) calories of formula. All supplies and equipment necessary to administer the nutrients in the beneficiary's place of residence, except the infusion pump and pump supply kit, are included in the unit description.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preference for formulae will not be considered for medical necessity.

A separate prior authorization must be obtained for the enteral infusion pump and the pump supply kit. The enteral infusion pump and the pump supply kit may be billed separately.

View or print the procedure codes for Hyperalimentation services.

Exceptions to Use of Formula

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk or soy protein; chronic diarrhea, short gut; cystic fibrosis, fat malabsorption due to GI, or liver disease.

D. Gerber Extensive HA – Allergy to milk or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome, known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24 – Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid Program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

~~HCPCS Code~~	~~M1~~	~~M2~~	~~M3~~	~~Description~~	~~Covered Formulae~~
~~B4149~~	~~U9~~			~~Enteral formula, blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit~~	

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4150	U9			Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4152	U9			Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml), with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4153	U9			Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4154	U9			Enteral formula, nutritionally complete, for special metabolic needs, includes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4155 Bill on Paper (Indicate specific name of formula on claims.)	U9			Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4155	U9	U1		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Polycose Powder Scandical
B4155	U9	U2		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Microlipid
B4155	U9	U3		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	
B4158	U9			Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4159	U9			Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	
B4159 (Ages 0-4 Years)	U9	U8		Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160	U9			Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160 (Ages 0-4 Years)	U9	U8		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4160	U9	U1		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160 (Ages 0-4 Years)	U9	U1	U8	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4161	U9			Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4161 Ages 5 to 99 Years	U9			Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4161 (Ages 0-4 Years)	U9	U8			
B4162	U9			Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4162	U9	U1		Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	

242.130 Pedia-Pop

11-1-17 10-1-22

The following procedure code must be utilized when billing for Pedia-Pop.

View or print the procedure codes for Hyperalimentation services.

Reimbursement for this product is the provider's cost plus ten percent (10%). Pedia-Pop is covered for eligible Medicaid beneficiaries of all ages. Pedia-Pop is only for oral consumption in frozen form and may not be appropriate for a hyperalimentation diet.

National Procedure Code	M1	M2	Description	Maximum Units	Deleted Local Code
B4103	EP	U1	**Pedia-Pop; 1 unit equals 1 box	2 units per date of service	Z2487

242.142 Equipment and Supplies for Enteral (Sole Source) Nutrition Therapy

7-1-07 10-1-22

Equipment and supplies necessary for the administration of enteral (sole source) nutrition therapy in the beneficiary's place of residence are included in the unit reimbursement price. Prior authorization is required for the enteral infusion pump and the pump supply kit and may be billed separately. The prior authorization request for the pump must contain supporting documentation to establish medical necessity (e.g., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome, etc.).

Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column; if not, an "N" is shown.

View or print the procedure codes for Hyperalimentation services.

Procedure Code	Description	PA Y/N
B9000	Enteral nutrition infusion pump – without alarm	Y
B9002	Enteral nutrition infusion pump – with alarm	Y
B4035	Enteral feeding supply kit; pump fed, per day	Y

242.143 Reimbursement for the Enteral (Sole Source) Nutrition Infusion Pump

~~9-1-05~~10-1-~~22~~4

Reimbursement for the enteral (sole source) nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized.

View or print the procedure codes for Hyperalimentation services.

Procedure codes ~~**B9000** and **B9002**~~ each represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan. Both codes are reimbursed on a per unit basis with 1 day equaling 1 unit of service.

The provider may bill for the infusion pump at a maximum of one (1) unit of service per day. Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for procedure codes ~~**B9000** and **B9002**~~. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

242.145 Equipment Repairs for the Enteral Nutrition Infusion Pump

~~1-15-11~~10-1-~~22~~4

Reimbursement for repairs of the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs are covered before the equipment becomes the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be mailed to the Utilization Review Section, Division of Medical Services as detailed in Section 220.000 of this manual. The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93.

Medicaid will not reimburse for additional repairs of an infusion pump after the provider has billed repair invoices totaling $290.93. If, after billing the Medicaid maximum allowed for repairs, the equipment is still not in proper working order, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code ~~**B9000** or **B9002**~~ after receiving prior authorization for the new piece of equipment.

To bill the Medicaid Program for repairs made to the enteral infusion pump, use the following procedure code.

View or print the procedure codes for Hyperalimentation services.

~~⁂~~(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the Arkansas Medicaid description.

~~Procedure Code~~	~~Modifier~~	~~Description~~	~~Prior Authorization Required?~~
~~K0739~~	~~U9~~	~~⁂(Repair or non-routine services for enteral nutrition infusion pump requiring the skill of a technician, parts or labor.)~~	~~Yes~~

242.402 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-22~~1~~

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes for Hyperalimentation services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

TOC not required

214.500 Laboratory and X-Ray Services Referral Requirements

~~1-15-16~~10-1-~~22~~1

A nurse practitioner referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order,* pertinent supplemental diagnosis supporting the need for the test(s).

A. Diagnostic facilities, hospital labs and outpatient departments performing reference diagnostics rely on the referring nurse practitioner to establish medical necessity.

B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.

C. Nurse practitioners must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.

D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.

E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling and/or conveyance of specimens are as follows:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

~~P9612~~	~~P9615~~	~~36415~~

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.620 Risk Management Services for High Risk Pregnancy

~~7-1-05~~10-1-~~22~~1

A nurse practitioner may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a nurse practitioner does not choose to provide

high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one service with a benefit limit of 32 cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional and psychosocial assessment by a nurse practitioner or a registered nurse on the nurse practitioner's staff, to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal and/or Newborn Record System or equivalent form includes:
    a. Medical history
    b. Menstrual history
    c. Pregnancy history
2. Nutritional assessment includes:
    a. 24 hour diet recall
    b. Screening for anemia
    c. Weight history
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

B. Case Management Services

Case management services are provided by a nurse practitioner, a licensed social worker or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services (e.g., locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist or health educator) include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy
6. Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.630 Fetal Non-Stress Test

~~1-15-16~~10-1-~~22~~4

The fetal non-stress test is *limited to 2 per pregnancy per beneficiary*. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

215.000 Fluoride Varnish Treatment

~~8-1-14~~10-1-~~22~~4

Arkansas Medicaid covers fluoride varnish application, ADA code ~~D1206~~, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Nurse Practitioner services.

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. The online training course can be accessed at **http://ar.train.org**. Each provider must maintain

documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

252.110 Billing Protocol for Computed Tomographic Colonography (CT)

~~1-15-16~~10-1-221

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Nurse Practitioner services.

~~74261~~	~~74262~~	~~74263~~

B. Billing protocol for CT colonography procedure codes ~~74261, 74262 and 74263~~:

1. CT colonography is billable electronically or on paper claims.
2. For the Nurse Practitioner, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.130 Special Billing Instructions

~~1-15-16~~10-1-242

A. Use the following procedure codes for billing.

View or print the procedure codes for Nurse Practitioner services.

~~National Code~~	~~Procedure Code Description~~
~~36430~~	~~Blood or blood components used for transfusions. This includes administration and all supplies used to perform the transfusion.~~
~~40899~~	~~Consideration of any claims with the unlisted procedure codes requires submission on a paper claim. The claim form must include a description of the service being represented by the unlisted code. Documentation that further describes the service provided must be attached and must support medical necessity.~~
~~T1015~~	~~Procedure code T1015 should be billed for a non-emergency nurse practitioner visit.~~

B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology

~~8-1-21~~10-1-221

The following Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Nurse Practitioner services.

81161	81200	81201	81202	81203	81205	81206	81207
81208	81209	81210	81211	81212	81213	81214	81215
81216	81217	81220	81221	81222	81223	81224	81225
81226	81227	81228	81229	81235	81240	81241	81242
81243	81244	81245	81250	81251	81252	81253	81254
81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281
81282	81290	81291	81292	81293	81294	81295	81296
81297	81298	81299	81300	81301	81302	81303	81304
81310	81315	81316	81317	81318	81319	81321	81322
81323	81324	81325	81326	81330	81331	81332	81340
81341	81342	81350	81355	81370	81371	81372	81373
81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405
81406	81407	81408					

252.132 Special Billing Requirements for Lab and X-Ray Services

~~1-15-16~~10-1-221

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met in order for payment to be approved.

View or print the procedure codes for Nurse Practitioner services.

~~Procedure Code~~	~~Diagnosis~~	~~Age Restriction~~	~~Special Instructions~~
81479			Requires paper billing with attachments that describe and justify the service represented by this procedure.
81500, 81503	View ICD Codes.	18y & up	

Procedure Code	Diagnosis	Age Restriction	Special Instructions
81508, 81509 81510, 81511 85112			Must indicate current condition of pregnancy
82777	View ICD Codes.	18y & up	
83951	View ICD Codes.		
86828, 86829 86830, 86831 86832, 86833 86834, 86835	View ICD Codes.		
86386	View ICD Codes.		
87389	View ICD Codes.		See Section 252.431, when billing family planning services.
88720	View ICD Codes.		
88740	View ICD Codes.		
88741	View ICD Codes.		

252.410 Clinic or Group Billing

4-1-0710-1-22

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one nurse practitioner in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code 99360 is payable when provided in the inpatient hospital setting by a nurse practitioner.

View or print the procedure codes for Nurse Practitioner services.

252.422 Detention Time (Standby Service)

10-13-03-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code 99360 must be used by nurse practitioners when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code 99360 is payable when provided in the inpatient hospital setting by a nurse practitioner.

252.424 Hospital Discharge Day Management

10-13-03-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code ~~99238~~, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures ~~99221 through 99233~~. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.426 Specimen Collections

~~1-15-16~~10-1-221

The policy in regard to collection, handling and/or conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

~~P9612~~	~~P9615~~

252.428 Services Not Considered a Separate Service from an Office Visit

~~10-13-03-~~221

Some services (e.g., pelvic examinations, prostatic massages, removal of sutures, etc.) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code ~~57410~~ should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Nurse Practitioner services.

252.430 Family Planning Services Program Procedure Codes

~~5-1-17~~10-1-221

A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

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

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

claim for payment to be sure that all criteria have been met. View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.

C. The following procedure code table explains the family planning visit services payable to nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

View or print the procedure codes for Nurse Practitioner services.

Procedure Code	Modifier(s)	Description
99401	FP, UA, SA	Family Planning Periodic Visit
99402	FP, SA	Family Planning Basic Visit

D. The following procedure code table explains family planning codes payable to nurse practitioners. Use the FP modifier for family planning services.

11976*	11981*	36415**	58300*	58301*	J1050	J7297	J7298
J7300	J7301	J7303	J7307				

*Bill using modifiers FP, SA.

**Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Use modifier FP for family planning services.

E. The following procedure codes are payable to Nurse Practitioners:

56501	57061	57420	57421	57452	57454	57455	57456

F. The following procedure code table explains the pathology procedure code payable to nurse practitioners.

NOTE: The procedure code with the modifiers indicated below denotes the Arkansas Medicaid description.

Procedure Code	Modifier(s)	Description
88302	FP, U1	Surgical Pathology, Elective Sterilization, Outpatient Professional Service

Family planning laboratory codes are found in Section 252.431.

252.431 Family Planning Laboratory Procedure Codes

5-1-1710-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The following procedure code table contains family planning laboratory procedure codes.

View or print the procedure codes for Nurse Practitioner services.

Family Planning Laboratory Codes							
Q0111***	81000	81001	81002	81003	81025	83020	83520
84703	85014	85018	85660	86592	86593	86687	86701
87075	87081	87088	87210	87389	87390	87470	87490
87491	87531	87536	87590	87591	87621**	88142*	88143*
88147	88148	88150**	88152	88153	88154	88155**	88164
88165	88166	88167	88174	88175	88302¤	89300	89310
89320							

*Procedure codes 88142 and 88143 are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

¤See points B and C below for information regarding this procedure code.

B. Laboratory codes payable to **non-hospital-based nurse practitioners.**

The following procedure code table contains laboratory services payable to non-hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Procedure Code	Required Modifier(s)	Description
88302	FP	Surgical Pathology, Complete Procedure, Elective Sterilization
88302	FP, U3	Surgical Pathology, Technical Component, Elective Sterilization

C. Laboratory codes payable to **hospital-based nurse practitioners.**

The following procedure code table describes the laboratory services payable to hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Procedure Code	Modifier(s)	Description
88302	FP, U1	Surgical Pathology, Elective Sterilization, Outpatient Professional Service.

252.439 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-22~~1~~

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes for Nurse Practitioner services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.441 Family/Group Psychotherapy

~~1-15-16~~10-1-22~~1~~

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Nurse Practitioner services.

~~National Codes~~		
~~90847~~	~~90849~~	~~90853~~

Procedure codes ~~**90847** and **90849**~~ are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code ~~**90847**~~ is payable only when the patient is present during the treatment. Procedure codes ~~**90849** and **90853**~~ are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.443 Other Covered Injections

~~7-1-07~~10-1-~~22~~24

Nurse practitioners billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Nurse Practitioner services.

~~Procedure Code~~	~~Procedure Description~~
~~J0170~~	~~Adrenaline, Epinephrine, Injection, up to 1 ml ampule. (Payable if performed on an emergency basis and is provided in the physician's office.)~~
~~J2996~~	~~Alteplase recombinant, Injection, 10 mg (Payable for eligible Medicaid beneficiaries of all ages.)~~
~~90581*~~	~~Anthrax vaccine, for subcutaneous use. Requires paper billing.~~
~~J2910~~	~~Aurothioglucose, Injection, up to 50 mg. (Payable for patients with a diagnosis of rheumatoid arthritis.)~~
~~J0702~~	~~Betamethasone acetate and Betamethasone sodium phosphate, injection, per 3 mg (Payable for beneficiaries of all ages. However, if the beneficiary is aged 21 or older the injection is covered only for malignant neoplasm, diagnosis code range 140–208.9 or complications related to pregnancy, diagnosis code range 640–648.9)~~
~~J0585*~~	~~Botulinum toxin type A, per unit. (Payable for eligible Medicaid beneficiaries of all ages when medically necessary.) Requires paper billing.~~
~~J0636~~	~~Calcitriol, Injection, 1 mcg ampule (This code is payable for eligible Medicaid beneficiaries of all ages receiving dialysis due to acute renal failure, diagnosis codes 584-586.)~~
~~J1100~~	~~Dexamethasone sodium phosphate, injection, 1 mg (Payable for beneficiaries of all ages. However, if the beneficiary is aged 21 or older the injection is covered only for diagnoses of malignant neoplasm, code range 140–208.9 or for complications relating to pregnancy, code range 640–648.9)~~
~~Q0187~~	~~Factor VIIa (coagulation factor, recombinant) for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Arkansas Medicaid will approve payment for Factor VIIa only when the primary diagnosis is 286.0, 286.1, 286.2 or 286.4.~~
~~J1460~~	~~Gamma globulin injections, intramuscular, 1 cc (covered for all ages with no diagnosis restrictions)~~

Procedure Code	Procedure Description
J1470	Gamma globulin injections, intramuscular, 2 cc (covered for all ages with no diagnosis restrictions)
J1480	Gamma globulin injections, intramuscular, 3 cc (covered for all ages with no diagnosis restrictions)
J1490	Gamma globulin injections, intramuscular, 4 cc (covered for all ages with no diagnosis restrictions)
J1500	Gamma globulin injections, intramuscular, 5 cc (covered for all ages with no diagnosis restrictions)
J1510	Gamma globulin injections, intramuscular, 6 cc (covered for all ages with no diagnosis restrictions)
J1520	Gamma globulin injections, intramuscular, 7 cc (covered for all ages with no diagnosis restrictions)
J1530	Gamma globulin injections, intramuscular, 8 cc (covered for all ages with no diagnosis restrictions)
J1540	Gamma globulin injections, intramuscular, 9 cc (covered for all ages with no diagnosis restrictions)
J1550	Gamma globulin injections, intramuscular, 10 cc (covered for all ages with no diagnosis restrictions)
J1560	Gamma globulin injections, intramuscular, over 10 cc (covered for all ages with no diagnosis restrictions)
J1563	Immune globulin, intravenous 1g (covered for all ages with no diagnosis restrictions)
J1564	Immune globulin, intravenous 10 mg (covered for all ages with no diagnosis restrictions)
J7199*	Hemophilia clotting factor, not otherwise classified (Payable for Medicaid beneficiaries of all ages effective for dates of service on and after June 1, 2002.)
90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use. (Payable for eligible Medicaid beneficiaries under age 21.)
90660*	Influenza virus vaccine, live, for intranasal use
90659	Influenza virus vaccine, whole virus, for intramuscular or jet injection use. (Payable for eligible Medicaid beneficiaries age 12 and older.)
J1750	Iron dextran, injection, 50 mg (Payable for eligible Medicaid beneficiaries of all ages receiving dialysis due to acute renal failure.)
90735	Japanese encephalitis virus vaccine, for subcutaneous use (payable for under age 21.)
J9219	Leuprolide acetate implant, 65 mg (Effective for dates of service on or after July 1, 2003. This procedure code is covered for males of all ages with ICD-9-CM diagnosis codes 185, 198.82 or V10.46. Benefit limit is one procedure every 12 months.
J2260	Milrinone Lactate (Primacor), per 5 ml (payable for eligible Medicaid beneficiaries of all ages with congestive heart failure (diagnosis codes 428-428.9) with places of service "2", "X", "3" or "4."

Procedure Code	Procedure Description
90732	Pneumococcal polysaccharide vaccine 23-valent, adult dosage, for subcutaneous or intramuscular use. (This code is payable for eligible Medicaid beneficiaries age 12 and over. Patients age 21 and older who receive the injection should be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.)
J2790	Rho D immune globulin, injection, human, one dose package 300 mcg, (RhoGAM). (Limited to one injection per pregnancy.)
J2916	Sodium ferric gluconate complex in sucrose injection, 62.5 mg (Covered for Medicaid eligible beneficiaries of all ages who are allergic to iron dextran. However, if the patient is aged 21 and over there must be a diagnosis of malignant neoplasm (diagnosis code range 140.0-208.91, HIV disease (diagnosis code 042), or acute renal failure (diagnosis code range 584-586)
90703	Tetanus toxoid, absorbed, for intramuscular or jet injection use. (Payable for eligible Medicaid beneficiaries of all ages.)
J3420	Vitamin B-12 cyanocobalamin, Injection, up to 1000 mcg. (Payable for patients with a diagnosis of pernicious anemia. Code includes the B-12, administration and supplies and may not be billed by units.)

* Procedure code requires paper billing.

National Code	Required Modifier	Local Code	Local Code Description
90371	—	Z1757	Hepatitis B Immune Serum Globulin (ISG) (One unit equals 1/2 cc with a maximum of 10 units billable per day.) (Payable for eligible Medicaid beneficiaries of all ages in the physician's office, nurse practitioner's office, outpatient hospital or dialysis facility.)
90385 J2788	—	Z2501	Rho (D) immune globulin, injection, human, one pre-filled single dose syringe, 50 mcg, MICRhoGAM. (Limited to one per pregnancy.)
90707	U1	Z2633	Maternal Measles/Mumps/Rubella (MMR) (Payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these illnesses. Coverage is limited to two (2) injections per lifetime.)
90669	—	Z2691	Prevnar™ vaccine (pneumoccal 7-valent), pediatric (This vaccine should be given in four doses at 2, 4, 6 and 12 to 15 months of age. Older children ages 24 to 59 months may receive the vaccine if they have special health conditions. Reimbursement is for administration only.)

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine

~~10-13-03~~ 22~~1~~

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Nurse Practitioner services.

~~90375~~	~~90376~~	~~90675~~	~~90676~~

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs

~~9-1-2010-1-~~ 22~~1~~

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Nurse Practitioner services.

~~1. **J2315** – Injection, naltrexone, depot form, 1 mg~~

~~2. **J0570** – Buprenorphine implant, 74.2 mg~~

~~3. **Q9991** – Injection, buprenorphine extended release (Sublocade), less than or equal to 100 mg~~

~~4. **Q9992** – Injection, buprenorphine extended release (Sublocade), greater than 100 mg~~

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

252.449 Influenza Virus Vaccine

~~7-1-0710-1-~~ 22~~1~~

View or print the procedure codes for Nurse Practitioner services.

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

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

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code ~~90656~~, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

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

C. Effective for dates of service on and after October 1, 2005, procedure code ~~90660~~, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

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

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

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

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

252.450 Obstetrical Care and Risk Management Services for Pregnancy ~~12-5-05~~10-1-22~~1~~

Covered nurse practitioner obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A nurse practitioner may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the nurse practitioner employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered to be one service and are limited to 32 cumulative units.

View or print the procedure codes for Nurse Practitioner services.

~~National Code~~	~~Required Modifiers~~	~~Description~~
~~99402~~	~~SA, U1, UA~~	~~Risk Assessment~~
~~99402~~	~~SA, U4, UA~~	~~Case Management Services, low-risk case~~
~~99402~~	~~SA, U5, UA~~	~~Case Management Services, high-risk case~~
~~99402~~	~~SA, UA~~	~~Perinatal Education~~
~~99402~~	~~SA, U3, UA~~	~~Social Work Consultation~~
~~99402~~	~~SA, U2, UA~~	~~Nutrition Consultation – Individual~~

For an early discharge home visit, use one of the applicable CPT procedure codes~~: 99341, 99343, 99347, 99348~~ and ~~99349~~.

252.451 Fetal Non-Stress Test

~~10-13-03~~ 22~~4~~

The Fetal Non-Stress Test (procedure code ~~59025~~) is limited to 2 per pregnancy. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity.

View or print the procedure codes for Nurse Practitioner services.

252.452 Newborn Care

~~4-23-10~~10-1-22~~4~~

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. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Nurse Practitioner services.

For routine newborn care following a vaginal delivery or C-section, procedure codes ~~99460, 99461~~ or ~~99463~~ must be used one time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a nurse practitioner.

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

Procedure codes ~~99460, 99461~~ and ~~99463~~ may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (e.g., neonatal jaundice), use procedure codes ~~99221~~ through ~~99233~~. Do not use procedure codes ~~99460, 99461~~ and ~~99463~~ in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and 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)~~

ARKids First B requires a CMS-1500 claim form and 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)~~

252.453 Fluoride Varnish Treatment

~~8-1-2110-1-22~~

View or print the procedure codes for Nurse Practitioner services.

The American Dental Association (ADA) procedure code ~~D1206~~ is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code ~~D1206~~, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code ~~D1206~~ (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services

~~2-1-2010-1-22~~

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

View or print the procedure codes for Nurse Practitioner services.

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
~~99406*~~	~~SE~~	~~**(Smoking and tobacco use cessation counseling visit;~~

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
		~~intermediate, 15-minutes)~~
~~99406*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15-minutes provided to parents of children birth through twenty (20) years of age)~~
~~99407*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intensive, 30-minutes)~~
~~99407*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30-minutes provided to parents of children birth through twenty (20) years of age)~~

*Exempt from PCP referral requirements.

⁂**(…)**This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing ~~1-15-16~~10-1-22~~1~~

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the nurse practitioner. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Nurse Practitioner services.

~~Physical Therapy~~			
~~Procedure Code~~	~~Modifier(s)~~	~~Description~~	~~Benefit Limit~~
~~97110~~		~~Individual Physical Therapy~~	~~15-minute unit. Maximum of 4 units per day.~~

Physical Therapy			
Procedure Code	**Modifier(s)**	**Description**	**Benefit Limit**
97110	UB	Individual Physical Therapy by Physical Therapy Assistant	15-minute unit. Maximum of 4 units per day.
97150		Group Physical Therapy	15-minute unit. Maximum of 4 units per day; Maximum of 4 clients per group.
97150	UB	Group Physical Therapy by Physical Therapy Assistant	15-minute unit. Maximum of 4 units per day; Maximum of 4 clients per group.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART)

10-1-22 11-15-16

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Nurse Practitioner services.

Procedure Code	Limitations
87901	A maximum of 12 units per 12 month period.
87903	A maximum of 1 unit per year.
87904	This procedure code is an add-on code.
87906	1 unit per day.

252.457 Procedures That Require Prior Authorization

1-15-16 10-1-22

A. The following procedure code requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 220.000 of this manual for prior authorization instructions.)

20974

B. The following Molecular Pathology codes require prior authorization from AFMC.

View or print the procedure codes for Nurse Practitioner services.

81161	81200	81201	81202	81203	81205	81206	81207
81208	81209	81210	81211	81212	81213	81214	81215
81216	81217	81220	81221	81222	81223	81224	81225

81226	81227	81228	81229	81235	81240	81241	81242
81243	81244	81245	81250	81251	81252	81253	81254
81255	81256	81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275	81280	81281
81282	81290	81291	81292	81293	81294	81295	81296
81297	81298	81299	81300	81301	81302	81303	81304
81310	81315	81316	81317	81318	81319	81321	81322
81323	81324	81325	81326	81330	81331	81332	81340
81341	81342	81350	81355	81370	81371	81372	81373
81374	81375	81376	81377	81378	81379	81380	81381
81382	81383	81400	81401	81402	81403	81404	81405
81406	81407	81408					

252.462 Non-Emergency Services

~~1-15-16~~10-1-22~~1~~

Procedure code ~~T1015~~ should be billed for a non-emergency nurse practitioner visit.

View or print the procedure codes for Nurse Practitioner services.

252.484 Injections, Therapeutic and/or Diagnostic Agents

~~8-~~10-1-22~~1~~

Nurse practitioners shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

View or print the procedure codes for Nurse Practitioner services.

TOC not required

213.000 Outpatient Behavioral Health Services Program Entry

~~10-1-2213-1-19~~

Prior to continuing provision of Counseling Level Services, the provider must document medical necessity of Outpatient Behavioral Health Counseling Services. The documentation of medical necessity is a written intake assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate. This documentation must be made part of the beneficiary's medical record.

The intake assessment, either the Mental Health Diagnosis ~~(CPT Code 90791)~~, Substance Abuse Assessment ~~(CPT Code H0001)~~, or Psychiatric Assessment ~~(CPT Code 90792)~~, must be completed prior to the provision of Counseling Level Services in the Outpatient Behavioral Health Services program. This intake will assist providers in determining services needed and desired outcomes for the beneficiary. The intake must be completed by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health and/or substance use disorders.

View or print the procedure codes for OBHS services.

231.100 Prior Authorization

~~10-1-2213-1-19~~

Prior Authorization is required for certain Outpatient Behavioral Health Services provided to Medicaid-eligible beneficiaries.

Prior Authorization requests must be sent to the DMS contracted entity to perform prior authorizations for beneficiaries under the age of 21 and for beneficiaries age 21 and over for services that require a Prior Authorization. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

Procedure codes requiring prior authorization:

View or print the procedure codes for OBHS services.

~~National Codes~~	~~Required Modifier~~	~~Service Title~~
~~90832~~	~~UC, UK, U4~~	~~Individual Behavioral Health Counseling – Age 3~~
~~90834~~	~~UC, UK U4~~	~~Individual Behavioral Health Counseling – Age 3~~
~~90837~~	~~UC, UK, U4~~	~~Individual Behavioral Health Counseling – Age 3~~
~~90847~~	~~UC, UK, U4~~	~~Marital/Family Behavioral Health Counseling with Beneficiary Present – Dyadic Treatment~~
~~H2027~~	~~UK, U4~~	~~Psychoeducation – Dyadic Treatment~~

231.300 Substance Abuse Covered Codes

~~10-1-2213-1-19~~

Certain Outpatient Behavioral Health Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Independently Licensed Practitioners

may provide Substance Abuse Service within the scope of their practice. Behavioral Health Agency sites must be licensed by the Divisions of Provider Services and Quality Assurance in order to provide Substance Abuse Services. Allowable substance abuse services are listed below:

View or print the procedure codes for OBHS services.

National Codes	Required Modifier	Service Title
90832	U4 U5	Individual Behavioral Health Counseling – Substance Abuse
90834	U4 U5	Individual Behavioral Health Counseling – Substance Abuse
90837	U4 U5	Individual Behavioral Health Counseling – Substance Abuse
90853	U4 U5	Group Behavioral Health Counseling – Substance Abuse
90846	U4 U5	Marital/Family Behavioral Health Counseling – without Beneficiary Present – Substance Abuse
90847	U4 U5	Marital/Family Behavioral Health Counseling with Beneficiary Present – Substance Abuse
90849	U4 U5	Multi-Family Behavioral Health Counseling – Substance Abuse
90791		Mental Health Diagnosis
90887		Interpretation of Diagnosis
H0001	U4	Substance Abuse Assessment

Beneficiaries being treated by an Outpatient Behavioral Health Service provider for a mental health disorder who also have a co-occurring substance use disorder(s), this (these) substance use disorder(s) is (are) listed as a secondary diagnosis. Outpatient Behavioral Health Service Agency providers that are certified to provide Substance Abuse services may also provider substance abuse treatment to their behavioral health clients. In the provision of Outpatient Behavioral Health mental health services, the substance use disorder is appropriately focused on with the client in terms of its impact on and relationship to the primary mental health disorder.

A Behavioral Health Agency and Independently Licensed Practitioner may provide substance abuse treatment services to beneficiaries who they are also providing mental health/behavioral health services to. In this situation, the substance abuse disorder must be listed as the secondary diagnosis on the claim with the mental health/behavioral health diagnosis as the primary diagnosis.

252.111 Individual Behavioral Health Counseling

10-1-2213-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services. ~~90832, U4~~ ~~90834, U4~~ ~~90837, U4~~ ~~90832, U4, GT – Telemedicine~~ ~~90834, U4, GT – Telemedicine~~ ~~90837, U4, GT – Telemedicine~~ ~~90832, U4, U5 – Substance Abuse~~ ~~90834, U4, U5 – Substance Abuse~~ ~~90837, U4, U5 – Substance Abuse~~ ~~90832, UC, UK, U4 – Under Age 4~~ ~~90834, UC, UK, U4 – Under Age 4~~ ~~90837, UC, UK, U4 – Under Age 4~~	~~90832: p~~Psychotherapy, 30 min ~~90834: p~~Psychotherapy, 45 min ~~90837: p~~Psychotherapy, 60 min

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with Mental Health Diagnosis • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the diagnosis, or medication concerns • Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive or crisis plans • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Services provided must be congruent with the objectives and interventions articulated on the most recent Mental Health Diagnosis. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy	~~90832: 30~~ 30 minutes ~~90834: 45~~ 45 minutes ~~90837: 60~~ 60 minutes	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: One encounter between

is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service. This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.	**View or print the procedure codes for OBHS services.**	all three codes. YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 encounters between all 3 codes
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults Residents of Long Term Care Facilities	A provider may only bill one Individual Behavioral Health Counseling Code per day per beneficiary. A provider cannot bill any other Individual Behavioral Health Counseling Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling encounters allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90853, U4~~ ~~90853, U4, U5 – Substance Abuse~~	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with Mental Health Assessment • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for diagnosis, or medication concerns • Plan for next group session, including any homework assignments and/ or crisis plans • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This does NOT include psychosocial groups. Beneficiaries eligible for Group Behavioral Health Counseling must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 encounters

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling encounters allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present

10-1-2213-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90847, U4~~ ~~90847, U4, U5 – Substance Abuse~~ ~~90847, UC, UK, U4 – Dyadic Treatment *~~	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or

parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized and is only available for beneficiaries in Tier 1. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).	regression and prognosis • Any changes indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed and dated

NOTES	UNIT	BENEFIT LIMITS
Natural supports may be included in these sessions if justified in service documentation and if supported in the documentation in the Mental Health Diagnosis. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiaries: 12 encounters

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient encounter per day. There are 12 total Marital/Family Behavioral Health Counseling with Beneficiary Present encounters allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. **The following codes cannot be billed on the**

	Same Date of Service: ~~90849 –~~Multi-Family Behavioral Health Counseling ~~90846 –~~Marital/Family Behavioral Health Counseling without Beneficiary Present ~~H2027 – –~~Psychoeducation **View or print the procedure codes for OBHS services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.114 Marital/Family Behavioral Health Counseling without Beneficiary Present

~~10-1-2213-1-19~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90846, U4~~ ~~90846, U4, U5 – Substance Abuse~~	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling without Beneficiary Present is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop	• Date of Service • Start and stop times of actual encounter spouse/family • Place of service • Participants present and relationship to

alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.	beneficiary • Diagnosis and pertinent interval history • Brief observations with spouse/family • Rationale for, and description of treatment used that must coincide with the Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed and dated

NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation and if supported in Mental Health Diagnosis. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiaries: 12 encounters

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Beneficiary encounter per day. **The following codes cannot be billed on the Same Date of Service:** ~~90849 –~~Multi-Family Behavioral Health Counseling ~~90847 –~~Marital/Family Behavioral Health

	Counseling with Beneficiary Present ~~H2027 - -~~ Psychoeducation **View or print the procedure codes for OBHS services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.115 Psychoeducation

~~10-1-22~~13-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~H2027, U4~~ ~~H2027, U4, GT – Telemedicine~~ ~~H2027, UK, U4 – Dyadic Treatment*~~	Psychoeducational service; per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to,**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated diagnosis, or

<table>
<tr><td>Nurturing Parents and Incredible Years.</td><td colspan="2">medication concerns
• Plan for next session, including any homework assignments and/or crisis plans
• HIPAA compliant Release of Information forms, completed, signed and dated
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.</td><td>15 minutes</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill a total of 48 units of Psychoeducation

The following codes cannot be billed on the Same Date of Service:
~~90847 –~~Marital/Family Behavioral Health Counseling with Beneficiary Present
~~90846 –~~Marital/Family Behavioral Health Counseling without Beneficiary Present
View or print the procedure codes for OBHS services.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face
Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services</td><td colspan="2">02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)</td></tr>
</table>

○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.116 Multi-Family Behavioral Health Counseling

~~10-1-22~~13-~~1-19~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90849, U4~~ ~~90849, U4, U5 – Substance Abuse~~	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their family members or significant others. Services are a more cost-effective alternative to Marital/Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter with beneficiary and/or spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
May be provided independently if patient is	Encounter	DAILY MAXIMUM OF

being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.		ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	There are 12 total Multi-Family Behavioral Health Counseling encounters allowed per year. **The following codes cannot be billed on the Same Date of Service:** ~~90846~~ – Marital/Family Behavioral Health Counseling without Beneficiary Present ~~90847~~ – Marital/Family Behavioral Health Counseling with Beneficiary Present ~~90887~~ – Interpretation of Diagnosis ~~90887~~ – Interpretation of Diagnosis, Telemedicine **View or print the procedure codes for OBHS services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.117 Mental Health Diagnosis

10-1-2123-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90791, U4~~ ~~90791, U4, GT – Telemedicine~~ ~~90791, UC, UK, U4 – Dyadic Treatment *~~	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the

current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions • Treatment recommendations, and prognosis for treatment • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes This service can be provided via telemedicine to beneficiaries only ages 21 and above. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:** ○ **Presenting symptoms and behaviors;** ○ **Developmental and medical history;** ○ **Family psychosocial and medical history;** ○ **Family functioning, cultural and communication patterns, and**	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1

current environmental conditions and stressors; ○ **Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;** ○ **Child's affective, language, cognitive, motor, sensory, self-care, and social functioning.**		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults Residents of Long Term Care	**The following codes cannot be billed on the Same Date of Service:** ~~90792 –~~ Psychiatric Assessment **View or print the procedure codes for OBHS services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults Only)	Counseling	
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

252.118 Interpretation of Diagnosis

~~10-1-2213-1-19~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.~~90887, U4~~	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family

~~90887, U4, GT – Telemedicine~~ ~~90887, UC, UK, U4 – Dyadic Treatment~~	or other responsible persons, or advising them how to assist patient

SERVICE DESCRIPTION	MINIMUM DOCUMENTATION REQUIREMENTS
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face-to-face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the Mental Health Diagnosis • Participant(s) response and feedback • Recommendation for additional supports including referrals, resources and information • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary; the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader**	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1

perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** ~~H2027 –~~Psychoeducation ~~90792 –~~Psychiatric Assessment ~~90849 –~~Multi-Family Behavioral Health Counseling ~~H0001 –~~Substance Abuse Assessment **View or print the procedure codes for OBHS services.** This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine Adults, Youth and Children	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

treatment of Children age 0-47 months & Parent/Caregiver) Provider	

252.119 Substance Abuse Assessment

10-1-2213-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.H0001, U4	Alcohol and/or drug assessment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DAABHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions • Treatment recommendations and prognosis for treatment • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
The assessment process results in the assignment of a diagnostic impression, beneficiary recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary, initial plan (provisional) of care and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the beneficiary for a psychiatric consultation	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** 90887 —Interpretation of Diagnosis

	View or print the procedure codes for OBHS services.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.120 Psychological Evaluation

10-1-22~~13-1-19~~

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for OBHS services.~~96130, U4~~ ~~96131, U4~~	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g., MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or	• Date of Service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic

psychiatric conditions • history and symptomatology are not readily attributable to a particular psychiatric diagnosis • questions to be answered by the evaluation could not be resolved by a Mental Health Diagnosis or Psychiatric Assessment, observation in therapy, or an assessment for level of care at a mental health facility • the service provides information relevant to the beneficiary's continuation in treatment and assists in the treatment process	• Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
This code may not be billed for the completion of testing that is considered primarily educational or utilized for employment, disability qualification, or legal or court related purposes.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children, Youth, and Adults	~~96130~~ used for first hour of service ~~96131~~ used for any additional hours of service **View or print the procedure codes for OBHS services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Psychologist (LP) • Licensed Psychological Examiner (LPE) • Licensed Psychological Examiner – Independent (LPEI)	03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.121 Pharmacologic Management

~~10-1-22~~~~13-1-19~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	~~99212:~~ Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key

~~99212, UB, U4 – Physician~~ ~~99213, UB, U4 – Physician~~ ~~99214, UB, U4 – Physician~~ ~~99212, UB, U4, GT – Physician, Telemedicine~~ ~~99213, UB, U4, GT – Physician, Telemedicine~~ ~~99214, UB, U4, GT – Physician, Telemedicine~~ ~~99212, SA, U4 – APN~~ ~~99213, SA, U4 – APN~~ ~~99214, SA, U4 – APN~~ ~~99212, SA, U4, GT – APN, Telemedicine~~ ~~99213, SA, U4, GT – APN, Telemedicine~~ ~~99214, SA, U4, GT – APN, Telemedicine~~	components: A problem focused history; A problem focused examination; Straightforward medical decision making ~~99213:~~ Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. ~~99214:~~ Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity **View or print the procedure codes for OBHS services.**
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms with the goal of improving functioning, including management and reduction of symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (When 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included) • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the Psychiatric Assessment • Beneficiary's response to treatment that includes current progress or regression and prognosis • Revisions indicated for the diagnosis, or medication(s) • Plan for follow-up services, including any crisis plans • If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Applies only to medications prescribed to address targeted symptoms as identified in the	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT

Psychiatric Assessment.		MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 12
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Advanced Practice Nurse • Physician	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

252.122 Psychiatric Assessment

~~10-1-22~~13-1-19

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
~~90792, U4~~ ~~90792, U4, GT – Telemedicine~~ **View or print the procedure codes for OBHS services.**	Psychiatric diagnostic evaluation with medical services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • The interview should obtain or verify all of the following: 1. The beneficiary's understanding of the factors leading to the referral

<table>
<tr><td></td><td colspan="2">2. The presenting problem (including symptoms and functional impairments)
3. Relevant life circumstances and psychological factors
4. History of problems
5. Treatment history
6. Response to prior treatment interventions
7. Medical history (and examination as indicated)
• For beneficiaries under the age of 18
1. an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to:
a) Clarify the reason for the referral
b) Clarify the nature of the current symptoms
c) Obtain a detailed medical, family and developmental history.
• Culturally and age-appropriate psychosocial history and assessment
• Mental status/Clinical observations and impressions
• Current functioning and strengths in specified life domains
• DSM diagnostic impressions
• Treatment recommendations
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1
YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults
Telemedicine (Adults, Youth, and Children)</td><td colspan="2">The following codes cannot be billed on the Same Date of Service:
~~90791~~ Mental Health Diagnosis
View or print the procedure codes for OBHS services.</td></tr>
</table>

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
A. an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18) B. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC) **The PMHNP-BC must meet all of the following requirements:** A. Licensed by the Arkansas State Board of Nursing B. Practicing with licensure through the American Nurses Credentialing Center C. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC must be discussed with the supervising psychiatrist within 45 days of the beneficiary entering care. The collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat. D. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act E. Practicing within a PMHNP-BC's experience and competency level	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12, (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

255.001 **Crisis Intervention** ~~10-1-22~~~~13-1-19~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS	Crisis intervention service, per 15 minutes

services.~~H2011, HA, U4~~	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.) Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis ~~(90791)~~ within 7 days of provision of this service if provided to a beneficiary who is not currently a client. **View or print the procedure codes for OBHS services.** If the beneficiary cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the beneficiary must be placed in the beneficiary's medical record. If the beneficiary needs more time to be stabilized, this must be noted in the	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Crisis	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency) • Advanced Practice Nurse • Physician (must be employed by Behavioral Health Agency)	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)	

255.003 Acute Crisis Units

10-1-2213-1-19

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for OBHS services.~~H0018, U4~~	Behavioral Health; short-term residential	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**

Youth and Adults	Per Diem	• 96 hours or less per encounter • 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Acute Crisis Units must be certified by the Division of Provider Services and Quality Assurance as an Acute Crisis Unit Provider		
CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for OBHS services. ~~H0018, U4~~	Behavioral Health; short-term residential	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	Per Diem	• 96 hours or less per encounter • 1 encounter per month • 6 encounters per SFY

	PROGRAM SERVICE CATEGORY
	Crisis Services
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	N/A
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
N/A	21, 51, 55, 56

255.004 Substance Abuse Detoxification

~~3-1-19~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for OBHS services.~~H0014, U4~~	Alcohol and/or drug services; detoxification	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	• 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Substance Abuse Detoxification must be provided in a facility that is certified by the	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)	

Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider.	

TOC not required

242.110 Private Duty Nursing Services Procedure Codes

~~4-1-09~~10-1-224

The following procedure codes are applicable when billing the Arkansas Medicaid Program for private duty nursing services.

View or print the procedure codes for Private Duty Nursing (PDN) services.

~~Procedure Code~~	~~Modifier~~	~~Description~~
~~S9123~~		~~Private Duty Nurse, R.N.~~
~~S9124~~		~~Private Duty Nurse, L.P.N.~~
~~S9123*~~	~~U1~~	~~Supervisory Visit ;R.N~~

*Effective for dates of service on and after April 4, 2008 procedure code ~~S9123 U1~~ can be billed for a RN supervisory visit. The maximum time allowed for reimbursement per visit is 3 hours, with a maximum of 18 visits per state fiscal year. Supervisory visits (as defined by the Arkansas Department of Health Rules and Regulations for Home Health Agencies) must be face-to-face and provided in a setting approved for private duty nursing services (see Section 242.200). Beneficiaries receiving extended care will require no less frequency than every two weeks of supervision. For beneficiaries classified as stable or chronic (beyond the first 3 months of extended care), RN supervisory visits will be no less than every 30 days.

242.120 Simultaneous Care of Two Patients

~~10-1-2214-1-09~~

When a private duty nurse is caring for two patients simultaneously in the same location, the following procedure codes are to be used for the care provided to the second patient:

View or print the procedure codes for Private Duty Nursing (PDN) services.

~~Procedure Code~~	~~Required Modifier~~	~~Description~~
~~S9123~~	~~UB~~	~~Private duty nurse, RN, 2nd patient. Medicaid maximum allowable is 50% of the rate for S9123.~~
~~S9124~~	~~UB~~	~~Private duty nurse, LPN, 2nd patient. Medicaid maximum allowable is 50% of the rate for S9124.~~
~~S9123*~~	~~UB U1~~	~~Supervisory Visit ;R.N 2nd patient Medicaid maximum allowable is 50% of the rate for S9123~~

242.130 Medical Supplies Procedure Codes

~~10-1-2219-1-13~~

The following HCPCS procedure codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers will use the current Health Care Procedural Coding System (HCPCS) Book for procedure code descriptions.

~~A4206~~	~~A4207~~	~~A4209~~	~~A4216~~	~~A4217~~	~~A4221~~	~~A4222~~	~~A4253~~
~~A4256~~	~~A4259~~	~~A4265~~	~~A4310~~	~~A4311~~	~~A4312~~	~~A4313~~	~~A4314~~
~~A4315~~	~~A4316~~	~~A4320~~	~~A4322~~	~~A4326~~	~~A4327~~	~~A4328~~	~~A4330~~
~~A4331~~	~~A4338~~	~~A4340~~	~~A4344~~	~~A4346~~	~~A4349~~	~~A4351~~	~~A4352~~

A4353	A4354	A4355	A4356	A4357	A4358	A4361	A4362
A4364	A4365	A4367	A4368	A4369	A4371	A4394	A4397
A4398	A4399	A4400	A4402	A4404	A4405	A4406	A4407
A4414	A4435	A4450	A4452	A4454	A4455	A4483	A4558
A4560	A4561	A4562	A4623	A4624	A4625	A4626	A4628
A4629	A4772	A4927	A5051	A5052	A5053	A5054	A5055
A5056	A5057	A5061	A5062	A5063	A5071	A5072	A5073
A5081	A5082	A5093	A5102	A5105	A5112	A5113	A5114
A5121	A5122	A5126	A5131	A6154	A6196	A6197	A6198
A6200	A6201	A6202	A6209	A6210	A6211	A6216	A6217
A6218	A6219	A6220	A6221	A6228	A6229	A6230	A6234
A6235	A6236	A6237	A6238	A6239	A6241	A6242	A6243
A6244	A6245	A6246	A6247	A6248	A6257	A6258	A6259
A6441	A6442	A6443	A6444	A6445	A6446	A6447	A6448
A6449	A6450	A6451	A6452	A6453	A6454	A6455	A6549*
A7520	A7521	A7522	A7524	A7525	B4087	B4100	E0776

*Refer to **Section 242.430**.

Procedure codes shown below contain a modifier and an Arkansas Medicaid procedure code description.

View or print the procedure codes for Private Duty Nursing (PDN) services.

Procedure Code	M1	Description
A4253	UB	Blood Glucose test or reagent strip for home blood glucose monitor, per 25 strips
A4351	U1	Intermittent urinary catheter, disposable; straight tip
A4352	U1	Intermittent urinary catheter, disposable; curve tip
A4450	U1	Tape, all types, all sizes
A6197	UB	Alginate dressing, each (more than 16, but less than 48 sq. in.)
A6234	U1	Absorptive dressing (e.g. hydrocolloid), without adhesive
A6237	U1	Absorptive dressing (e.g. hydrocolloid), with adhesive
A6242	U1	NON-Absorptive dressing (e.g. hydrogel), adhesive, or non-adhesive
A6248	U1	Hydrogel dressing, wound cover, pad size 16 sq. in. or less w/o adhesive

Private duty nursing services (PDN) are billed on a per unit basis. One unit equals one hour. Arkansas Medicaid will reimburse for the actual amount of cumulative PDN time on a monthly basis. Service time of less than one hour will not be rounded up to a full hour. Attach supervisory visit billing information with supporting documentation and assessment with the monthly private duty nursing billing. No supervisory visits will be covered without first providing prior authorized private duty nursing services within the same month. Billing units are cumulative up to one hour for the duration of one month. Supervisory visits of less than an hour can be billed cumulatively on a monthly basis but any visit less than a unit (hour) cannot be rounded up. Providers must file separate claims indicating the number of hours for each patient.

Type of service code "1" must be used when filing paper claims. Public schools must use type of service code "S" when filing paper claims for beneficiaries under age 21.

Refer to Sections **242.110** and **242.120** for PDN procedure codes for single patient care and multiple patient care.

242.421 Simultaneous Care of Two Patients in the Beneficiaries' Home or a DDS Facility

~~10-1-22~~15-~~1-08~~

When a private duty nurse is caring for two patients simultaneously in a location other than a public school, Arkansas Medicaid reimburses 100% of the maximum allowable rate for the first patient and 50% of the maximum allowable rate for the second patient.

Providers must file separate claims indicating the number of hours of care for each patient.

Providers must request prior authorization for procedure codes ~~**S9123** and **S9124**~~.

View or print the procedure codes for Private Duty Nursing (PDN) services.

242.430 Private Duty Nursing Medical Supplies

~~10-1-22~~10-~~15-08~~

Procedure code ~~**A6549**~~, with types of service "**S**" and "**1**", must be manually priced. Procedure code ~~**A6549**~~ with a type of service of "**1**" requires a prior authorization (PA).

View or print the procedure codes for Private Duty Nursing (PDN) services.

Form DMS-679 may be used to request prior authorization. **View or print form DMS 679.**

TOC required

222.000 Fetal Non-Stress Test and Ultrasound Benefit Limits

~~10-1-22~~10-13-03

The Arkansas Medicaid Program covers the Fetal Non-Stress Test and the Ultrasound when performed in conjunction with maternity care. Refer to **Section 292.673** of this manual for procedure codes.

A. The Ultrasound and Fetal Non-Stress Test have a benefit limit of two (2) per pregnancy.

B. Post-procedural visits are covered within the 10-day period following a fetal non-stress test.

If it is necessary to exceed the Medicaid established benefit limits, the physician must request extension of the benefit with documentation that justifies the need for additional tests and establishes medical necessity.

223.000 Injections

~~2-15-15~~10-1-22~~4~~

A. The Arkansas Medicaid Program applies benefit limits to some covered injections.

B. For information on coverage of injections, special billing instructions and procedure codes, refer to Sections **292.595** and **292.950** of this manual.

225.200 Computed Tomographic Colonography (CT Colonography)

~~12-15-14~~10-1-22~~4~~

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~74261~~	~~74262~~	~~74263~~

B. CT colonography policy and billing

1. Virtual colonoscopy, also known as CT colonography, utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D and/or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy) and air insufflation to achieve colonic distention.
2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to an obstruction neoplasm, spasm, redundant colon, diverticulitis extrinsic compression or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon proximal to the obstruction would be of use to the surgeons in planning the operative approach to the patient.
3. Limitations:
   a. Virtual colonography is not reimbursable when used for screening or in the absence of signs or symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.
   b. Virtual colonography is not reimbursable when used as an alternative to

instrument/fiberoptic colonoscopy, for screening or in the absence of signs or symptoms of disease.

c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (e.g. biopsy) or for treatment (e.g. polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.

d. CT colonography procedure codes are counted against the beneficiary's annual lab and X- ray benefit limit.

e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.

f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of the abdomen and pelvis.

C. Documentation requirements and utilization guidelines

1. Each claim must be submitted with ICD codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. Claims submitted without ICD codes coded to the highest level of specificity will be denied.

2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography) which was incomplete must be retained in the patient's record.

3. The patient's medical record must include the following and be available upon request:

a. The order/prescription from the referring physician

b. Description of polyps/lesion:

i. Lesion size [for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views. The type of view employed for measurement should be stated];

ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon and cecum);

iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa); and

iv. Attenuation (soft-tissue attenuation or fat).

c. Global assessment of the colon (C-RADS categories of colorectal findings):

i. C0 - Inadequate study
poor prep (can't exclude > 10 lesions)

ii. C1 - Normal colon or benign lesions
no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum)

iii. C2 - Intermediate polyp(s) or indeterminate lesion
polyps 6 - 9 mm in size, <3 in number
indeterminate findings

iv. C3 - Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number

v. C4 - Colonic mass, likely malignant.

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 - Inadequate study limited by artifact

ii. E1 - Normal exam or anatomic variant

iii. E2 - Clinically unimportant findings (no work-up needed)

iv. E3 - Likely unimportant findings (may need work-up)
incompletely characterized lesions
e.g., hypodense renal or liver lesion

v. E4 - Clinically important findings (work-up needed)
e.g., solid renal or liver mass, aortic aneurysm, adenopathy

D. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy which was incomplete due to obstruction.

E. See Section 292.603 for billing protocol.

241.000 Fluoride Varnish Treatment

~~8-1-14~~10-1-22~~1~~

Arkansas Medicaid will expand coverage for fluoride varnish application, ADA code ~~D1206~~, to physicians and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The online training course can be accessed at **http://ar.train.org**. The provider will need to maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

242.000 Dermatology

~~7-1-07~~10-1-22~~1~~

The Arkansas Medicaid Program covers CPT procedure code ~~96900 -~~ Actinotherapy (ultraviolet light). The physician must submit documentation with claim to establish medical necessity.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

247.200 Risk Management Services for Pregnancy

~~3-15-05~~10-1-22~~1~~

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in the service descriptions below. If a physician does not choose to provide risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy.

Each of the covered risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

A. Risk Assessment

A medical, nutritional and psychosocial assessment is completed by the physician or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:

a. Medical history

b. Menstrual history

c. Pregnancy history

2. Nutritional assessment to include:
    a. Medical history
    b. Menstrual history
    c. Pregnancy history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status

Maximum: 2 units per pregnancy

B. Case Management Services

Services by a physician, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid gain access to needed medical, social, educational and other services (examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver the newborn, follow-up to verify the patient kept an appointment, rescheduling appointments). Services may be provided for low-risk or high-risk cases as determined by the risk assessment.

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (Physician, Public Health Nurse, Nutritionist, or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration, to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the physician or registered nurse employee may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the physician may request an early discharge home visit from any clinic which provides perinatal services. Visits will be done by physician order (including hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is a specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 292.676** of this manual.

250.200 Physician Assessment in the Hospital Emergency Department

~~10~~-1~~3-03-~~ 22~~1~~

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid has a physician assessment fee. (See **Section 292.682** for procedure code and billing instructions.) The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a primary care physician. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

251.220 Elective Abortions

~~8~~10-1-22~~1~~

Only medically necessary abortions are covered by Arkansas Medicaid. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest, defined under Ark. § Code Ann. 5-14-103 and § 5-22-202, as certified in writing by the woman's attending physician.

A. All abortions require prior authorization. A Certification Statement for Abortion (DMS-2698) must be completed prior to performing the procedure and is required for requesting prior authorization and billing. **View or print form DMS-2698**.

B. Other required documentation includes patient history and physical exam records. The physician performing the abortion is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. Refer to Section 292.410 for other billing instructions.

C. For abortions when the life of the mother would be endangered if the fetus were carried to term, prior authorization (PA) requests must be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting a review.**

D. Abortions for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services Utilization Review Section. **View or print the Utilization Review contact information.** Refer to Section 261.260 for instructions on requesting PA.

E. Payable Abortion Procedure Codes

1. For Professional or Outpatient Abortion Claims, the following codes are required:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~01966~~	~~59840~~	~~59841~~	~~59850~~
~~59851~~	~~59852~~	~~59855~~	~~59856~~

~~59857~~

2. For inpatient hospital facility Abortion Claims, the provider must use the following codes:
   a. 10A00ZZ – Abortion of Products of Conception, Open Approach
   b. 10A03ZZ – Abortion of Products of Conception, Percutaneous Approach
   c. 10A07Z6 – Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
   d. 10A07ZW – Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
   e. 10A07ZX – Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
   f. 10A07ZZ – Abortion of Products of Conception, Via Natural or Artificial Opening

251.230 Cochlear Implant and External Sound Processor Coverage Policy ~~8~~10-1-2~~2~~1

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. (See Section 261.120 for prior authorization requirements and Section 292.801 for billing protocol.)

A. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Program for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) Program when prescribed by a physician.

The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or a switch from a body worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware, are considered not medically necessary and will not be approved.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~2010 Codes~~	~~Modifier~~	~~Age Restriction~~	~~Manually Priced~~	~~Review~~	~~PA~~
~~L8627*~~	~~EP~~	~~0-20~~	~~Yes~~	~~No~~	~~Yes~~
~~L8628*~~	~~EP~~	~~0-20~~	~~Yes~~	~~No~~	~~Yes~~
~~L8629*~~	~~EP~~	~~0-20~~	~~Yes~~	~~No~~	~~Yes~~

*Denotes paper claim required

B. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

C. Personal FM Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems **(procedure code ~~V5273~~ for use with cochlear implant)** that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

D. Replacement, Repair, Supplies

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

254.000 Enterra Therapy for Treatment of Gastroparesis ~~8~~10-1-2~~2~~1

A. Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages eighteen (18) through sixty-nine (69) with diabetic and idiopathic gastroparesis (View ICD Codes.).

1. Service includes the implantable neurostimulator electrode(s) and the neurostimulator pulse generator.
2. Implantation procedures for neurostimulator pulse generator and the neurostimulator electrodes are covered as inpatient surgical procedures.
   a. The surgical procedures require prior authorization (PA) by DHS or its designated vendor.

      View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

   b. An approval letter from the Institutional Review Board is required. Patient's record must include documentation that further total parental nutrition (TPN) therapy is not an option.
3. Procedure for revision or removal of the peripheral neurostimulator electrodes does not require PA, but claim will be manually reviewed prior to reimbursement.

C. See Section 292.880 of this manual for procedure codes and billing instructions.

256.000 Gastrointestinal Tract Imaging with Endoscopy Capsule 10-1-15221

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

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

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

C. Documentation of medical necessity requires a primary detail diagnosis of one of the following ICD diagnosis codes (View ICD Codes.).

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

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

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

257.000 Tobacco Cessation Products and Counseling Services 810-1-221

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the designated Pharmacy Vendor website or in the Prescription Drug Program Prior Authorization Criteria.

A. Physician providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial prior authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patient. The prescriber must retain the counseling checklist in the patient records for audit. View or Print the Arkansas Be Well Referral Form.

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or EPSDT. These sessions do not require a PCP referral.

E. If beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid

number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to **Section 292.900** for procedure codes and billing instructions.

261.120 Prior Authorization of Cochlear Implant, External Sound Processor and Repair/Replacement Supplies ~~9-15-12~~10-1-22~~1~~

A. Arkansas Medicaid provides coverage for cochlear implantation and for the external sound processor for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Prior authorization by AFMC is required.

B. A written request signed by the physician performing the procedure is required. The request must be accompanied by medical documentation to support medical necessity. See Section 261.100 for prior authorization instructions.

C. Prior Authorization for Repair and/or Replacement of Cochlear Implant External Components and Supplies

A request for prior authorization of a medically necessary FM system (~~V5273~~ for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to the Arkansas Foundation for Medical Care (AFMC) using **DMS-679-A**. **(View or print form DMS-679-A**.) All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization.

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record. See Section 261.100 of this manual for prior authorization procedures. Refer to Section 292.801 for further billing instructions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Modifier~~	~~Description~~	~~Prior Authorization~~	~~PA Criteria~~	~~Units Allowed per Date of Service~~
~~L8615*~~	~~EP~~	~~Headset/headpiece for use with Cochlear implant device, replacement~~	~~Yes~~	~~1 per 3 years~~	~~2~~

Procedure Code	Modifier	Description	Prior Authorization	PA Criteria	Units Allowed per Date of Service
L8616*	EP	Microphone for use with cochlear implant device, replacement	Yes	1 per year	2
L8617*	EP	Transmitting coil for use with cochlear implant device, replacement	Yes	1 per year	2
L8618*	EP	Transmitter cable for use with cochlear implant device, replacement	Yes	4 per 6 months	8
L8619*	EP	Cochlear implant external speech processor, and controller, integrated system, replacement	Yes	5 years	2
L8621*	EP	Zinc air battery for use with cochlear implant device, replacement, each	Yes	180 units per 6 months	360
L8622*	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each	Yes	180 units per 6 months	360
L8623*	EP	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Yes	1 (set of 2) per year Unilateral	2
L8624*	EP	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	Yes	1 set of 2 per year Unilateral	2
L8627*	EP	Cochlear implant, external speech processor, component, replacement	Yes	Prior Authorized when not under warranty	2

Procedure Code	Modifier	Description	Prior Authorization	PA Criteria	Units Allowed per Date of Service
L8628*	EP	Cochlear implant, external controller component, replacement	Yes	Prior authorized when not under warranty	2
L8629*	EP	Transmitting coil and cable, integrated ,for use with cochlear implant device, replacement	Yes	1 per year	2
V5273	EP	Assistive listening device, for use with Cochlear implant	Yes	Prior Authorized when not covered through IDEA	1

261.250 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART)

9-15-1210-1-221

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure Code	Limitations
87901	A maximum of 12 units per 12 month period.
87903	A maximum of 1 unit per year.
87904	This procedure code is an add-on code.
87906	1 unit per day.

261.260 Prior Authorization of Elective Abortion of Pregnancy Resulting from Rape or Incest

8-1-0410-1-221

The following procedures must be followed to obtain prior authorization for elective abortion when pregnancy is the result of rape or incest:

A. The woman's physician must complete the Certification Statement for Abortion, form DMS-2698 (Rev. 8/04) certifying that the pregnancy resulted from forcibly compelled sexual intercourse or incest as defined under Ark. § Code Ann. 5-14-103 and § 5-22-202. **View or print form DMS-2698**.

1. The completed form DMS-2698 must include the name and address of the patient and be dated before the date of surgery.

2. The patient may sign the Certification Statement for Abortion (form DMS-2698) for herself at eighteen (18) years of age or older.

3. If the patient is under 18 years of age, then a parent or guardian must sign the Certification Statement for Abortion (form DMS-2698). The guardian must furnish a copy of the order appointing him or her guardian, or furnish the letters of guardianship issued by the court clerk.

B. Effective for dates of service on and after August 1, 2004, the physician must fax a completed form DMS-2698, patient history and medical exam records to the Department of Human Services (DHS), Division of Medical Services (DMS), Administrator, Utilization Review Section, for prior authorization of the abortion procedure. **View or print the Division of Medical Services Utilization Review contact information**.

C. DMS Utilization Review Section will convey its decision to the physician within 24 hours; or, if necessary, will request more information for the DMS physician's review. A DMS physician's review is required when UR reviewers deny authorization or need a physician's expertise.

D. The provider must submit the claim and required documentation for payment to the Department of Human Services, Division of Medical Services, Attention: Administrator, Utilization Review. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. **View or print the Division of Medical Services Utilization Review contact information.**

If the patient needs the Certification Statement for Abortion form (DMS-2698) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator**. View or print the Americans with Disabilities Act Coordinator contact information.**

Refer to **Section 292.410** for special billing instructions and procedure codes.

262.000 Procedures That Require Prior Authorization

~~4-1-14~~**10-1-22**~~1~~

A. The following procedure codes require prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 261.100 of this manual for prior authorization instructions.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Codes~~							
~~J7330~~	~~S0500~~	~~S0512~~	~~S2066~~	~~S2067~~	~~S2112~~	~~V2623~~	~~V2625~~
~~01966~~	~~11960~~	~~11970~~	~~11971~~	~~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~~	~~36470~~	~~36471~~	~~37785~~
~~37788~~	~~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~~	~~48155~~	~~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~~	~~61870~~	~~61875~~	~~61880~~	~~61885~~	~~61886~~	~~61888~~	~~63650~~
~~63655~~	~~63661~~	~~63662~~	~~63663~~	~~63664~~	~~63685~~	~~63688~~	~~64555~~
~~64568~~	~~64569~~	~~64570~~	~~64585~~	~~64590~~	~~64809~~	~~64818~~	~~65710~~
~~65730~~	~~65750~~	~~65755~~	~~65756~~	~~67900~~	~~69300~~	~~69310~~	~~69320~~
~~69714~~	~~69715~~	~~69717~~	~~69718~~	~~69930~~	~~99183~~		

** Denotes that AFMC Prior Authorization is required if these procedure codes are used to save the life of the mother and a Utilization Review Prior Authorization is required in cases for rape or incest. Refer to Sections 251.220, 261.200 and 261.260 for additional information.

B. The following 2013 CPT® Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for additional billing information.

~~81161~~	~~81201~~	~~81202~~	~~81203~~	~~81235~~	~~81252~~	~~81253~~	~~81254~~
~~81321~~	~~81322~~	~~81323~~	~~81324~~	~~81325~~	~~81326~~	~~G0452~~	

C. The following 2012 Molecular Pathology CPT® procedure codes require a prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for billing additional information.

~~81200~~	~~81205~~	~~81206~~	~~81207~~	~~81208~~	~~81209~~	~~81210~~	~~81211~~
~~81212~~	~~81213~~	~~81214~~	~~81215~~	~~81216~~	~~81217~~	~~81220~~	~~81221~~
~~81222~~	~~81223~~	~~81224~~	~~81225~~	~~81226~~	~~81227~~	~~81228~~	~~81229~~
~~81240~~	~~81241~~	~~81242~~	~~81243~~	~~81244~~	~~81245~~	~~81250~~	~~81251~~
~~81255~~	~~81256~~	~~81257~~	~~81260~~	~~81261~~	~~81262~~	~~81263~~	~~81264~~

~~81265~~	~~81266~~	~~81267~~	~~81268~~	~~81270~~	~~81275~~	~~81280~~	~~81281~~
~~81282~~	~~81290~~	~~81291~~	~~81292~~	~~81293~~	~~81294~~	~~81295~~	~~81296~~
~~81297~~	~~81298~~	~~81299~~	~~81300~~	~~81301~~	~~81302~~	~~81303~~	~~81304~~
~~81310~~	~~81315~~	~~81316~~	~~81317~~	~~81318~~	~~81319~~	~~81330~~	~~81331~~
~~81332~~	~~81340~~	~~81341~~	~~81342~~	~~81350~~	~~81355~~	~~81370~~	~~81371~~
~~81372~~	~~81373~~	~~81374~~	~~81375~~	~~81376~~	~~81377~~	~~81378~~	~~81379~~
~~81380~~	~~81381~~	~~81382~~	~~81383~~	~~81400~~	~~81401~~	~~81402~~	~~81403~~
~~81404~~	~~81405~~	~~81406~~	~~81407~~	~~81408~~			

D. The following procedure codes require prior authorization by the Arkansas Division of Medical Services Utilization Review. (See Section 261.200 for instructions regarding prior authorization with the Division of Medical Services. See Section 292.950 for additional billing information and coverage criteria.)

~~J7321~~	~~J7323~~	~~J7324~~	~~J7325~~

263.000 Prescription Drug Prior Authorization ~~9-1-2010~~-1-~~22~~4

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a provider with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Refer to the **DHS contracted Pharmacy vendor's website** for the following information:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be completed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

E. Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

1. ~~**J2315** – Injection, naltrexone, depot form, 1 mg~~
2. ~~**J0570** – Buprenorphine implant, 74.2 mg~~
3. ~~**Q9991** – Injection, buprenorphine extended-release (Sublocade), less than or equal to 100 mg~~
4. ~~**Q9992** – Injection, buprenorphine extended-release (Sublocade), greater than 100 mg~~

To access prior approval of these HCPCS procedure codes when necessary, reference the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor's website**.

292.410 Abortion Procedure Codes

~~810~~-1-2~~21~~

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from DHS or its designated vendor.

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

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

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

Use the following procedure codes when billing for abortions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~01966~~	~~59840~~	~~59841~~	~~59850~~	~~59851~~	~~59852~~
~~59855~~	~~59856~~	~~59857~~			

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

292.420 Allergy and Clinical Immunology

~~7-1-07~~10-1-2~~21~~

Allergy testing is available for all eligible Medicaid beneficiaries regardless of age, but allergy immunotherapy is payable only for eligible children under the Child Health Services (EPSDT) Program.

When charges for children under the Child Health Services (EPSDT) Program are billed to the Medicaid Program for the above services, the health care provider should check “Yes” in the child screening referral section of the claim, Field 24H, on the CMS-1500 claim form only if the service is a direct referral resulting from a Child Health Services (EPSDT) screen (examination). **View a CMS-1500 sample form.**

Appropriate CPT procedure codes should be used when billing for procedures listed in the allergy and clinical immunology section of the CPT book.

Reimbursement of allergy testing will be paid on a “per test” basis. Enter the exact number of tests performed in the “Units” field. Procedure codes ~~95070~~ and ~~95071~~ must be billed.

Procedure code ~~95078~~ is not a payable code.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

All laboratory tests done in conjunction with allergy testing or immunotherapy must also be billed by the provider who actually performs the test. Refer to Section 292.600 of this manual for information on specimen collection.

292.430 Ambulatory Infusion Device

~~9-15-12~~10-1-22~~1~~

Procedure code ~~E0779~~, modifier **RR**, **Ambulatory Infusion Device**, is payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

One unit of service equals one day. A reimbursement rate has been established and represents a daily rental amount. See Section 261.210 of this manual for Prior Authorization information.

292.440 Anesthesia Services

~~10~~-1-22~~1~~

Anesthesia procedure codes (**00100** through **01999**) must be billed in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate, anesthesia procedure codes that have a base of four (4) or fewer are eligible to be billed with a second modifier, **"22,"** referencing surgical field avoidance.

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

For electronic claims for Anesthesia services (procedure codes 00100 through 01999), total minutes should be billed in the units field.

B. Paper Claims

If paper billing is required, enter the procedure code, time, and units as shown in Section 292.447. Enter again the number of units (each fifteen (15) minutes of anesthesia equals one (1) time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

C. The following CPT procedure codes require attachments or documentation.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Description~~	~~Documentation Required~~
~~00800~~	~~Anesthesia for procedures on lower anterior abdominal wall; not otherwise specified~~	~~Operative Report~~
~~00840~~	~~Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified~~	~~Operative Report~~
~~00840~~ ~~Modifier UI~~	~~Anesthesia for Abdominal Hysterectomy~~	~~Operative Report~~ ~~Acknowledgement of Hysterectomy Information (DMS-2606)~~ ~~**View or print form DMS-2606 and instructions for completion.**~~

Procedure Code	Description	Documentation Required
00840 Modifier U2	Anesthesia for Laparoscopic Hysterectomy	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00840 Modifier U3	Anesthesia for Supra-cervical Hysterectomy, any method	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00846	Radical hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00848	Pelvic exenteration	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
00922	Anesthesia for procedures on male genitalia (including open urethral procedures); seminal vessels	Operative Report
00940	Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); not otherwise specified	Operative Report
00944	Vaginal hysterectomy	Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01962	Anesthesia for urgent hysterectomy following delivery	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01963	Anesthesia for cesarean hysterectomy without labor analgesia/anesthesia care	Operative Report Acknowledgement of Hysterectomy Information (DMS-2606) **View or print form DMS-2606 and instructions for completion.**
01965	Anesthesia for incomplete or missed abortion procedure	Procedure requires the following ICD diagnosis code (**View ICD Codes.**). Any other diagnosis billed with this procedure code requires paper billing and documentation to justify the procedure

~~Procedure Code~~	~~Description~~	~~Documentation Required~~
~~01966~~	~~Anesthesia for induced abortions. Use for billing anesthesia services for all elective, induced abortions, including abortions performed for rape or incest.~~	~~Operative Report~~ ~~Certification Statement for Abortion (DMS-2698). (See Sections 251.220, 261.000, 261.100, 261.200, and 261.260 of this manual.)~~ **~~View or print form DMS-2698 and instructions for completion.~~**
~~01999~~	~~Unlisted anesthesia procedure(s)~~	~~Procedure Report~~

*****Other documentation may be requested upon review.**

D. Anesthesiologist/anesthetists may bill procedure code ~~00170~~ for any inpatient or outpatient dental surgery using place of service code "**11**," "**21**," "**22**", or "**24**," as appropriate. This code does not require Prior Approval for anesthesia claims.

E. A maximum of seventeen (17) units of anesthesia are allowed for a vaginal delivery or Cesarean Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or Cesarean Section deliveries. Only one (1) anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.442 Epidural Therapy

~~7-1-07~~10-1-~~22~~4

Procedure code ~~62319~~ should be billed with one (1) unit of service at the time of insertion only. Providers are to bill for daily pain management utilizing procedure code ~~01996~~, with one time unit of 15 minutes, with no additional payment to the anesthetist for hospital visits. In cases where the method of anesthesia for surgery is an epidural anesthetic, providers are not allowed to re-bill for the insertion of a catheter for pain management unless there is documentation attached to verify two separate insertions were done. CPT procedure codes describing catheter and/or reservoir/pump implantation are to be used for long-term therapy.

Procedure code ~~93503~~ must be billed when performed by an anesthesiologist/CRNA.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.443 Medicaid Coverage for Therapeutic Infusions (Excludes Chemotherapy)

10-1-~~06~~22~~1~~4

Effective for dates of service on and after March 1, 2006, procedure codes ~~90780~~ and ~~90781~~ are non-payable. These codes have been replaced with procedure codes ~~99143~~ through ~~99150~~.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.446 Time Units

~~9~~10-1-2~~1~~4

Time units will be added to the Base Value and the Anesthesia Modifier for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

Enter the time units in Field 24G for paper claims. If filing electronically, the value submitted in this field should be the total anesthesia in minutes.

Anesthesia stand-by should be billed as detention time using procedure code ~~99360~~**.** One unit equals 30 minutes. A maximum of one unit per date of service may be billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.470 Fluoride Varnish Treatment

~~8~~10-1-2~~21~~

The American Dental Association (ADA) procedure code ~~D1206~~ is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus (1) day for beneficiaries under age twenty-one (21).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code ~~D1206~~ (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20). View a CMS-1500 sample form.

292.480 Cataract Surgery

~~7-1-07~~10-1-2~~21~~

Post-cataract lens implant must be billed using procedure code ~~V2630~~. This procedure code may be billed electronically or on paper. The lens implant code is billed in conjunction with the cataract surgery and is covered for eligible Medicaid beneficiaries of all ages in the outpatient setting.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.490 Clinical Brachytherapy

10-1~~3-03~~-2~~21~~

The following is clarification regarding Medicaid's policy for hospital admissions, daily visits and discharges in conjunction with clinical brachytherapy. CPT currently states, "Services **77750** through **77799** include admission to the hospital and daily visits." The Medicaid Program does not cover separate payment for hospital admissions or inpatient physician visits when procedure codes ~~77750 through 77799~~ are billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.510 Dialysis

10-1-~~15~~2~~21~~

A. Hemodialysis

The following procedure codes must be used by the nephrologist when billing for acute hemodialysis on hospitalized patients. Class I and Class II must have a secondary diagnosis listed to justify the level of care billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Required Modifier~~	~~Description~~
~~90937~~		~~Class I – Acute renal failure complicated by illness or failure of other organ systems~~
~~90935~~		~~Class II – Acute renal failure without failure of other organ systems but with other dysfunction in other areas requiring attention~~
~~99221~~ ~~99231~~	~~U1~~ ~~U1~~	~~Class III – Acute renal failure with minor or no other complicating medical problems~~

These are global codes. Hospital visits are included and must not be billed separately.

B. Peritoneal Dialysis

The following procedure codes must be used when billing for physician inpatient management of peritoneal dialysis. Class I and Class II must have a secondary diagnosis code listed to justify the level of care billed.

~~Procedure Code~~	~~Required Modifier(s)~~	~~Description~~
~~90947~~		~~Class I – Acute renal failure complicated by illness or failure of other organ systems (peritoneal dialysis)~~
~~90945~~		~~Class II – Acute renal failure, without failure of other organ systems but with dysfunction in other areas receiving attention (peritoneal dialysis)~~
~~99221~~ ~~99231~~	~~UB~~ ~~UB~~	~~Class III – Acute renal failure with minor or no other complicating medical problems~~

These are global codes. Hospital visits are included and must not be billed separately.

C. Outpatient Management of Dialysis

The Arkansas Medicaid Program will reimburse for outpatient management of dialysis under procedure codes ~~**90967**, **90968**, **90969** and **90970**~~.

One day of dialysis management equals one unit of service. A provider may bill one day of outpatient management for each day of the month unless the beneficiary is hospitalized. When billing for an entire month of management, be sure to include the dates of management in the "Date of Service" column. Only one month of management must be reflected per claim line with a maximum of 31 units per month. If a patient is hospitalized, these days must not be included in the monthly charge. These days must be split billed. An example is:

Date of Service	Procedures, Services or Supplies CPT/HCPCS	Days or Units
6-1-10 through 6-14-10	90967	14
6-21-10 through 6-30-10	90967	11

Arkansas Medicaid also covers Iron Dextran for beneficiaries of all ages who receive dialysis due to acute renal failure. Use procedure code **J1750** when administering in a physician's office.

Procedure codes **J0636** and **Q0139** are payable for eligible Medicaid beneficiaries of all ages who receive dialysis due to acute renal failure (**View ICD Codes.**).

292.521 Consultations

7-1-0710-1-221

When billing for office consultations when the place of service is the provider's office (POS: **11**) or inpatient hospital (POS: **21**), use the appropriate CPT procedure codes according to the description of each level of service.

The consultation procedure codes listed below must be used when the place of service is outpatient hospital or emergency room-hospital (POS: **22** or **23**, respectively) or ambulatory surgical center (POS **24**).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure Code	Required Modifier(s)	Description
99241	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: A problem-focused history, A problem-focused examination and Straightforward medical decision-making.
99242	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: An expanded problem-focused history, An expanded problem-focused examination and Straightforward medical decision-making.
99243	UA, UB	Other Outpatient Consultation for a new or established patient, which requires these three key components: A detailed history; A detailed examination and Medical decision making of low complexity.
99244	U1, UA	Other Outpatient Consultation for a new or established patient, which requires these three key components: A comprehensive history, A comprehensive examination and Medical decision making of moderate complexity.

~~Procedure Code~~	~~Required Modifier(s)~~	~~Description~~
~~99245~~	~~U1, UA~~	~~Other Outpatient Consultation for a new or established patient, which requires these three key components:~~ ~~A comprehensive history, An expanded problem-focused examination and Medical decision making of high complexity.~~

Medicaid does not cover follow-up consultations. A consulting physician assuming care of a patient is providing a primary evaluation and management service and bills Medicaid accordingly within CPT standards.

For information on benefit limits for all consultation (inpatient and outpatient) refer to Section 226.100 of this manual.

292.523 Detention Time

~~10-13-03~~ 1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code ~~99360~~ must be used by physicians when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code ~~99360~~ is payable when provided in the inpatient hospital setting by a physician.

292.525 Hospital Discharge Day Management

~~7-1-07~~1~~0~~-1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code ~~99238~~, hospital discharge day management, may not be billed by providers in conjunction with an initial or subsequent hospital care code, procedures ~~99221~~ through ~~99233~~. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

292.530 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.)

~~10-13-03~~ 1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Payment for E.S.W.L. is available through the Medicaid Program for the “physician operator” and the “aftercare physician.” The physician operating the lithotripter must use CPT procedure code ~~50590~~. If a bilateral procedure is done, enter a “2” in the units column. The physician who did not perform the surgery but who referred the patient to the facility for the lithotripsy procedure and will provide “aftercare” services, should bill for the actual services rendered. The anesthesiologist should follow normal billing procedures. Refer to Sections 251.260 and 272.400 of this manual for coverage and reimbursement information.

292.540 Factor VIII, Factor IX and Cryoprecipitate

~~7-1-07~~1~~0~~-1-22~~1~~

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician’s office or in the patient’s home. The following procedure codes must be used:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~J7190~~ Factor VIII [antihemophilic factor (human)], per IU

~~J7191~~ Factor VIII [antihemophilic factor (porcine)], per IU

~~J7192~~ Factor VIII [antihemophilic factor (recombinant)], per IU

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code ~~J7194~~ must be used when billing for Factor IX Complex (human). Factor IX Complex (Human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

The Arkansas Medicaid Program covers procedure code ~~P9012~~ Cryoprecipitate. This procedure is covered when provided to eligible Medicaid beneficiaries of all ages in the physician's office, outpatient hospital setting or patient's home.

Providers must attach a copy of the manufacturer's invoice to the claim form when billing for Cryoprecipitate.

For the purposes of Factor VIII, Factor IX and Cryoprecipitate coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

292.551 Family Planning Services For Beneficiaries ~~5-1-17~~1-1-22

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in Section 292.552.

A. Sterilization

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

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

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

00851¤	11976	11981	55250	55450	58300	58301	58340**
58345**	58565**	58600	58605	58611	58615	58661*	58670
58671	58700*	72190**	74740**	74742**	99144**	99145**	36415***
J1050	J7297	J7298	J7300	J7301	J7302	J7303	J7307

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

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Procedure Code	Modifier(s)	Description
99401	FP, UA, U1	Family Planning Periodic Arkansas Department of Health visit
99402	FP, UA	Family Planning Basic Arkansas Department of Health visit
99401	FP, UA, UB	Family Planning Periodic Physician visit
99402	FP, UA ,UB	Family Planning Basic Physician visit

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

11976	11981	55250	55450	58300	58301	58340**	58345**
58565**	58600	58615	58661*	58670	58671	58700*	72190**
74740**	74742**	99144**	99145**				

*CPT codes **58661** and **58700** represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~99401~~	~~U6~~	~~Family Planning Periodic Clinic Physician visit~~
~~99402~~	~~U6~~	~~Family Planning Basic Clinic Physician visit~~

F. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~88302~~	~~U1~~	~~Surgical Pathology, Elective Sterilization, Outpatient Professional Service.~~

Family planning laboratory codes are found in **Section 292.552**.

292.552 Family Planning Laboratory Procedure Codes

~~12-18-15~~10-1-221

Family planning services are covered for beneficiaries in full coverage aid categories and the limited coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning, as listed in Section A below. Laboratory codes payable to hospital-based physicians are listed in Section 292.552 (C) below.

A. The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Family Planning Laboratory Codes~~							
~~Q0111~~	~~81000~~	~~81001~~	~~81002~~	~~81003~~	~~81025~~	~~83020~~	~~83520~~
~~84703~~	~~85014~~	~~85018~~	~~85660~~	~~86592~~	~~86593~~	~~86687~~	~~86701~~
~~87075~~	~~87081~~	~~87088~~	~~87210~~	~~87389~~	~~87390~~	~~87470~~	~~87490~~
~~87491~~	~~87531~~	~~87536~~	~~87590~~	~~87591~~	~~87621**~~	~~88142*~~	~~88143*~~
~~88147~~	~~88148~~	~~88150**~~	~~88152~~	~~88153~~	~~88154~~	~~88155**~~	~~88164~~
~~88165~~	~~88166~~	~~88167~~	~~88174~~	~~88175~~	~~88302¤~~	~~89300~~	~~89310~~
~~89320~~							

*Procedure codes ~~88142 and 88143~~ are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

¤See points B and C below for information regarding this procedure code.

¤¤When **not** billing for family planning, see Section 292.602.

B. Laboratory codes payable to **non-hospital-based** physicians

The following procedure code table explains laboratory services payable to non-hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

~~Procedure Code~~	~~Required Modifier(s)~~	~~Description~~
~~88302~~	~~FP~~	~~Surgical Pathology, Complete Procedure, Elective Sterilization~~
~~88302~~	~~FP, U2~~	~~Surgical Pathology, Professional Component, Elective Sterilization~~
~~88302~~	~~FP, U3~~	~~Surgical Pathology, Technical Component, Elective Sterilization~~

C. Laboratory codes payable to **hospital-based** physicians

The following procedure code table describes the laboratory services payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

292.560 Genetic Services

~~11-1-17~~10-1-22~~4~~

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

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~National Code~~	~~Revenue Code Description~~
~~84702~~	~~Prenatal screening for fetal anomalies using maternal serum HCG and AFP~~

A. Documentation

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

B. Prenatal Diagnosis Counseling

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

1. Family, medical, pregnancy history
2. Psychosocial assessment and counseling of couple regarding genetic testing and disorder

3. Diagnosis, prognosis, available options, pregnancy management are explained to the couple.

C. Services Not Performed by a Physician

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

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

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

292.561 Hysteroscopy for Foreign Body Removal

~~4-1-14~~10-1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code ~~58562~~ requires paper billing and clinical documentation for justification.

292.580 Hysterectomies

~~11-1-17~~10-1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Physicians may use nationally recognized procedure code ~~58150-UA~~ when billing for a total hysterectomy procedure when the diagnosis is malignant neoplasm or severe dysplasia. See Section 251.280 for additional coverage requirement.

Procedure code ~~58150-UA~~ does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1500. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code ~~59525~~ is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

292.591 Molecular Pathology

~~810~~-1-22~~1~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code ~~G0452~~ requires prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.**

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 all pertinent clinical documentation needed to justify the procedure.

Reconsideration of a denied request is allowed if new or additional information is received within thirty (30) days of the initial denial. A copy of the **DMS-841** is located in Section V of this provider manual. View or print form DMS-841. Do not complete DMS-841 unless you are submitting a Molecular Pathology Prior Authorization request. **Molecular Pathology procedure codes must be submitted on a red line CMS-1500 claim form with the Prior Authorization number listed on the claim form and the itemized invoice attached which supports the charges for the test billed.**

Use Healthcare Common Procedural Coding System Level II (HCPCS) procedure code ~~G0452~~ for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for ~~G0452~~ must be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841). Prior authorization for ~~G0452~~ must be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for ~~G0452~~ must include the CPT Molecular Pathology procedure code for which the Interpretation and Report is to be provided. ~~G0452~~ must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology code(s) specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number. The invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

See Section 262.000 for additional information on Molecular Pathology procedure codes.

292.600 Laboratory and X-Ray Services

~~4-1-14~~10-1-~~22~~4

Only laboratory and X-ray services carried out in the physician's office or under his/her direct supervision may be billed by the physician to the Medicaid Program. Laboratory and X-ray services ordered by the physician but carried out in an outside facility must be billed directly to Medicaid by the outside facility. Physician will be reimbursed for collection fee only.

Medicaid regulations regarding collection, handling and/or conveyance of specimens are:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

NOTE: The P codes listed are the Urinary Collection Codes.

~~P9612~~	~~P9615~~	~~36415~~

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

292.602 Special Billing Requirements for Lab and X-Ray Services

10-1-15221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure Code	Diagnosis	Age Restriction	Special Instructions
81479			Requires paper billing with attachments that describe and justify the service represented by this procedure.
81500, 81503	View ICD Codes.	18y & up	
81508, 81509 81510, 81511 85112			Must indicate current condition of pregnancy
82777	View ICD Codes.	18y & up	
83951	View ICD Codes.		
86828, 86829 86830, 86831 86832, 86833 86834, 86835	View ICD Codes.		
86386	View ICD Codes.		
87389	View ICD Codes.		See Section 292.552, part A, when billing family planning services.
88720	View ICD Codes.		
88740	View ICD Codes.		
88741	View ICD Codes.		

292.603 Billing Protocol for Computed Tomographic Colonography (CT)

10-1-15221

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

74261	74262	74263

B. Billing protocol for CT colonography procedure codes 74261, 74262 and 74263:

1. CT colonography codes are covered with a primary ICD diagnosis of (View ICD codes.)
2. CT colonography is billable electronically or on paper claims.

See Section 225.200 for coverage protocol

292.620 Office Medical Supplies - Beneficiaries Under Age 21

~~11-01-09~~10-1-~~22~~1

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.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.650 NeuroCybernetic Prosthesis

1~~0~~-1~~3-03-~~22~~1~~

Arkansas Medicaid requires prior authorization for the following procedures related to the implantation, revision and removal of the NeuroCybernetic Prosthesis (NCP®), a vagus nerve stimulator (VNS):

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~National Codes~~			
~~63685~~	~~63688~~	~~64573~~	~~64585~~

292.660 Newborn Care

1~~0~~-1-~~15~~221~~

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 the Department of 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~~.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Note the descriptions, modifiers and required diagnosis range. For all providers, the newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis of (View ICD Codes.).

A. Physician Billing Instructions for Newborn Care

For ARKids First-A (EPSDT): Requires a CMS-1500 claim form; 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)~~

See Sections 241.000 – 242.400 of the EPSDT manual for specific EPSDT billing instructions.

For ARKids First-B: Requires a 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 ~~**99465**~~.

292.671 Method 1 - "Global" or "All-Inclusive" Rate

~~6-1-2010-1-221~~

The global method of billing should be used when one (1) or more physicians in a group see the patient for a prenatal visit and one (1) of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the beneficiary's physician visit benefit limit if the global method is billed.

A. One (1) charge for total obstetrical care is billed. The single charge includes the following:

1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to the pregnancy.
2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.
3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.
4. Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

B. The global method must be used when the following conditions exist:

1. At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.
2. The patient was continuously Medicaid eligible for two (2) months or more months before delivery and on the delivery date.

If either of the two (2) conditions is not met, the services will be denied, stating either "monthly billing required" or "beneficiary ineligible for service dates".

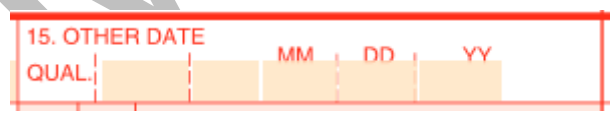
C. The correct codes for billing Medicaid for global obstetric care are as follows.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

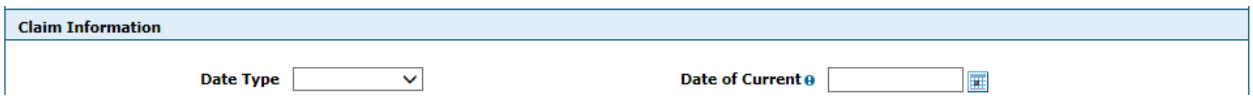
~~National Codes~~			
~~59400~~	~~59510~~	~~59610~~	~~59618~~

When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim. The delivery date is the date that is to be in the From and To Date of Service billed on the line with the above codes. The first date of antepartum care is to be billed in the "Initial Treatment Date" field.

For the CMS 1500 claim form, this is field 15 – Other Date Field. Qualifier 454 is required.



For the Provider Portal, the Date Type is "Initial Treatment Date" and the Date of Current is the first date of antepartum care.



If these two (2) dates are not entered and are not at least two (2) months apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.

292.672 Method 2 - "Itemized Billing" ~~810~~-1-2~~21~~

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided

B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. Date-of-service spans shall not include any dates for which the patient was ineligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~National Codes~~			
~~59410~~	~~59515~~	~~59614~~	~~59622~~

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

If Method 2 is used to bill for OB services, providers must ensure that the services are billed within the 365-day filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes ~~**59409** or **59612**~~ must be billed for vaginal delivery and procedure codes ~~**59514** or **59620**~~ must be billed for cesarean section. Procedure codes ~~**59400**, **59410**, **59510** and **59515**~~ shall not be billed in addition to procedure codes ~~**59409, 59612, 59514** or **59620**~~**.** These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician's standard office practice for billing OB patients. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are totally dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code ~~**80055**~~ consists of four components: Complete Blood Count, VDRL, Rubella and blood typing and RH. If the ASO titer ~~(procedure code **86060**)~~ is performed, the test must be billed separately using the individual code.

Only a collection may be filled for laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.673 Fetal Non-Stress Test and Ultrasound 10-1-~~06~~221

The Arkansas Medicaid Program covers the fetal non-stress test ~~(procedure code **59025**)~~ and the ultrasound ~~(procedure codes **76801 - 76828**)~~ when performed in conjunction with maternity care.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Arkansas Medicaid imposes a benefit limit of two medically necessary fetal non-stress test procedures per pregnancy. Fetal ultrasound is limited to two per pregnancy. If it is necessary to exceed these limits, the physician must request benefit extensions, when applicable, in accordance with benefit extension request instructions in this provider manual.

292.674 External Fetal Monitoring

~~7-1-07~~10-1-~~12~~

Procedure code ~~**59050**~~ must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code **"11.** Physicians may bill for one unit per day of external fetal monitoring. Physicians may bill for external fetal monitoring in addition to a global obstetric fee. When itemizing obstetric visits, physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.675 Obstetrical Care Without Delivery

~~7-1-07~~10-1-~~22~~

A. Obstetrical care without delivery may be billed using procedure code ~~**59425**~~, modifier **UA**, when 1 – 3 visits are provided and ~~**59425**~~ with no modifiers when 4 – 6 six visits are provided. Procedure code ~~**59426**~~ with no modifiers is payable for 7 or more visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

B. These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes are not counted against the patient's annual physician visit benefit limit. Reimbursement for each visit includes routine sugar and protein analysis. Other lab tests may be billed separately within 12 months of the date of service.

C. Providers must enter the dates of service in the CMS-1500 claim format and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

View a CMS-1500 sample form.

For example: An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. The Arkansas Medicaid fiscal agent must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: ~~**59425**~~ with modifier **UA** when 1 – 3 visits are provided, ~~**59425**~~ with no modifiers when 4 – 6 visits are provided and procedure code ~~**59426**~~ when 7 or more visits are provided.

292.676 Risk Management for Pregnancy

~~12-5-05~~10-1-~~22~~

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~
~~99402~~	~~U1, UA~~	~~Risk Assessment~~
~~99402~~	~~U4, UA~~	~~Case Management Services, low-risk~~
~~99402~~	~~U5, UA~~	~~Case Management Services, high-risk~~
~~99402~~	~~UA~~	~~Perinatal Education~~
~~99402~~	~~U3, UA~~	~~Social Work Consultation~~
~~99402~~	~~U2, UA~~	~~Nutrition Consultation – Individual~~

For early discharge home visits, use one of the applicable CPT procedure codes~~: **99341, 99343, 99347, 99348**, and **99349**~~.

292.682 Non-Emergency Services

~~7-1-07~~10-1-~~22~~1

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code ~~**T1015**~~, modifier **U1**, should be billed for a non-emergency physician visit in the emergency department. Procedure code ~~**T1015**~~, modifier **U1**, requires PCP referral. This procedure code is subject to the non-emergency outpatient hospital benefit limit of 12 visits per state fiscal year (SFY).

Physicians must use procedure code ~~**T1015**~~, modifier **U2**, **Physician Outpatient Clinic Services** for outpatient hospital visits. This service requires a PCP referral. Procedure codes ~~**T1015**~~, modifier **U1**, and ~~**T1015**~~, modifier **U2**, are subject to the benefit limit of 12 visits per SFY for non-emergency professional visits to an outpatient hospital for patients age 21 and over.

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid established a physician assessment fee. Procedure code ~~**T1015**~~, **Physician Assessment in Outpatient Hospital** is payable for beneficiaries enrolled with a PCP. The procedure code does not require PCP referral. The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a PCP. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

292.684 Outpatient Hospital Surgical Procedures

1~~0~~-1~~3-03~~-~~22~~1

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The CPT surgical codes ~~**(10040 - 69979)**~~ for the covered procedure should be used for billing. Reimbursement for the procedure will be based on the Medicaid Physician Fee Schedule. When billing a miscellaneous surgical code, attach an operative report.

292.690 Pelvic Examinations, Prostatic Massages, Removal of Sutures, Etc.

~~10-13-03~~ 1-22~~4~~

These services are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code ~~57410~~ should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.730 Professional and Technical Components

~~9-15-12~~10-1-22~~4~~

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Covered laboratory and radiology procedure codes in code range ~~70010 through 89399~~ as well as covered services listed in the Medicine section of CPT and HCPCS procedure codes manuals that require the use of a machine may be billed electronically or on paper. Codes in this range without an applicable modifier signify a complete procedure.

Applicable modifiers are required in Field 24D in addition to the procedure code. Modifier **TC** must be used for the technical component and modifier **26** must be used for the professional component.

292.742 Family/Group Psychotherapy

~~4-1-14~~10-1-22~~4~~

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~National Codes~~		
~~90847~~	~~90849~~	~~90853~~

Procedure codes ~~90847 and 90849~~ are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code ~~90847~~ is payable only when the patient is present during the treatment. Procedure codes ~~90849 and 90853~~ are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

292.760 Rural Health Clinic (RHC) Non-Core Services

~~9-15-12~~10-1-22~~4~~

Physician groups whose individual practitioners are contracting with a rural health clinic are limited to billing Medicaid for Rural Health Clinic (RHC) non-core services. These providers may bill the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

RHC NON-CORE SERVICES

Outpatient Hospital Visits	Inpatient Hospital Visits
Non-emergency: ~~T1015~~ modifier U1	~~99217 through 99223~~ ~~99231 through 99238~~ ~~99251 through 99255~~ ~~99291, 99295, 99296, 99297~~
Emergency: ~~99281 through 99285~~	
Electrocardiograms and Echocardiography Technical component only Modifier TC	**Radiology Technical component only Modifier TC**
~~93005, 93041, 93225, 93226, 93270, 93271, 93307, 93308, 93312, 93320, 93321, 93325, 93350~~	~~70010 through 76946~~ ~~76950 through 76977~~ ~~76999 through 78813~~ ~~78990 through 79999~~
Surgery, Outpatient and Inpatient	
All payable CPT procedure codes within range ~~10040 through 69990~~	

NOTE: Inpatient and outpatient hospital services are RHC non-core services only if the physician's contract with the RHC does not state that the physician will be compensated by the RHC for those services. Interpretation of X-rays and diagnostic machine tests in the inpatient or outpatient hospital is a non-core service when the visit itself is a non-core service. Home visits, nursing facility visits or other off-site visits are RHC encounters if the physician's agreement with the RHC requires that he or she provide the services and seek compensation from the RHC. Any of these off-site services is payable separately (through the Physician Program) from the RHC encounter fee if it is not a part of the physician's contract with the RHC.

See Sections 201.120 and 246.000 of this manual for additional information.

292.770 Sexual Abuse Examination for Beneficiaries 0 - 20 Years

~~10~~-1-~~15~~221

The procedure code **for Sexual Abuse Examination** listed in the table below is payable to physicians when provided in the physician's office or in a hospital outpatient department, emergency or non-emergency, with National Place of Service: **code "11", "23" or "22"**. This procedure is exempt from the PCP referral requirement and is covered for beneficiaries 0 - 20 years.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Modifier~~	~~Description~~	~~Diagnosis Code~~
~~99205~~	~~U2~~	~~Sexual Abuse Examination~~	~~View ICD Codes.~~

292.790 Surgical Procedures with Certain Diagnosis Ranges

~~10~~-1-~~15~~221

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

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Procedure Code~~	~~Procedure Description~~	~~Diagnosis Range~~

Procedure Code	Procedure Description	Diagnosis Range
44950	Appendectomy	View ICD Codes.
44955	Appendectomy w/other procedure	View ICD Codes.
44960	Appendectomy with abscess	View ICD Codes.
44970	Laparoscopic appendectomy	View ICD Codes.
49520	Hernia	View ICD Codes.

292.801 Cochlear Implant and External Sound Processor Billing Protocol 4-1-1410-1-221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code **69930** - Cochlear device implantation, with or without mastoidectomy - may be billed only by the physician performing the surgical procedure. When the cochlear device is provided by the physician, the physician may bill procedure code **L8614** for the cochlear device using **EP** modifier. Paper claims require a modifier **EP** for the device. Procedure code **69930** and **L8614** require prior authorization. The physician must attach a copy of the invoice to the CMS-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill for the device. Refer to Section 251.230 of this manual for coverage information.

Procedures are covered for beneficiaries under age 21 and must be billed with modifier **EP**.

The following procedure codes must be prior authorized. (See Section 261.120 for Prior Authorization requirements and Section 251.230 for coverage policy). Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

Some cochlear implant parts have previously been covered services under an unlisted procedure code.

The table below contains new and existing HCPCS procedure codes of FM system for use with a cochlear implant and replacement cochlear implant parts.

Please note: Coverage and billing requirements to the physician provider for cochlear device implantation is unchanged. (See Section 251.230 for coverage requirements.)

Billing and Reimbursement Protocol for FM system and replacement cochlear implant parts:

Procedure codes **L8615, L8616, L8617, L8618, L8619, L8623, L8627, L8628, L8629 and V5273** will be billable electronically or on paper. Claims with procedures codes requiring paper billing must be submitted with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. **V5273** mMay be submitted electronically or on a paper claim form. Provider charges for an FM system that is meant to be used with a cochlear implant **(V5273)** should reflect the retail price. Reimbursement of an FM system to be used with a cochlear implant **(V5273)** will be at 68 percent of the retail price.

Procedure Code	Modifier	Description	PA	PA Criteria	Units Allowed per Date of Service

Procedure Code	Modifier	Description	PA	PA Criteria	Units Allowed per Date of Service
L8615	EP	Headset/headpiece for use with Cochlear implant device, replacement	Yes	1 per 3 years	2
L8616	EP	Microphone for use with cochlear implant device, replacement	Yes	1 per year	2
L8617	EP	Transmitting coil for use with cochlear implant device, replacement	Yes	1 per year	2
L8618	EP	Transmitter cable for use with cochlear implant device, replacement	Yes	4 per 6 months	8
L8619	EP	Cochlear implant external speech processor, and controller, integrated system, replacement	Yes	5 years	2
L8621*	EP	Zinc air battery for use with cochlear implant device, replacement, each	Yes	180 units per 6 months	360
L8622*	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each	Yes	180 units per 6 months	360
L8623	EP	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Yes	1 (set of 2) per year Unilateral	2
L8624*	EP	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	Yes	1 (set of 2) per year Unilateral	2
L8627	EP	Cochlear implant, external speech processor, component, replacement	Yes	Prior authorized when not under warranty	2
L8628	EP	Cochlear implant, external controller	Yes	Prior authorized	2

Procedure Code	Modifier	Description	PA	PA Criteria	Units Allowed per Date of Service
		component, replacement		when not under warranty	
L8629	EP	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	Yes	1 per year	2
V5273	EP	Assistive listening device, for use with Cochlear implant	Yes	Prior authorized when not covered through IDEA	1

* Indicates requirement of paper billing with manufacturer invoice attached.

292.821 Billing for Corneal Transplants

9-15-1210-1-221

The following CPT procedure codes are payable for corneal transplants with prior approval: 65710, 65730, 65750, 65755 and 65756.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Medicaid will reimburse the physician for the acquisition and preservation of the cornea. Medicaid will not reimburse for the transportation of the cornea. HCPCS procedure code V2785 must be used when billing for the acquisition and preservation of the cornea. This code must be billed in conjunction with the transplant surgery. An itemized statement for the acquisition and preservation of the cornea must accompany the CMS-1500 claim form. **View a CMS-1500 sample form.**

292.822 Billing for Renal (Kidney) Transplants

10-1-15221

A. The following CPT procedure codes are payable for renal transplants with prior approval: 50320, 50340, 50360, 50365, 50370 and 50380.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code 50300 is non-payable.

1. A separate claim must be filed for the donor. If the donor is not Medicaid eligible, the claim should be filed under the Medicaid beneficiary's name and Medicaid ID number. Diagnosis code (**View ICD Codes.**) (Donors, kidney) must be used for the renal donor and diagnosis code (**View ICD Codes.**) (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.
2. If the donor is a Medicaid beneficiary, the claim must be filed utilizing the donor's Medicaid ID number. However, the diagnosis codes listed above must be used.

B. HCPCS procedure code ~~A0434~~, modifier **UA**, must be used by providers billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code ~~A0434~~, modifier **UA**, on the claim in conjunction with the transplant surgery. An itemized statement for the transportation and preservation of the kidney must accompany form CMS-1500. **View a CMS-1500 sample form.**

292.823 Billing for Pancreas/Kidney Transplants - Under Age 21

~~3-15-05~~10-1-~~22~~1

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The appropriate CPT procedure code should be used when billing for pancreas/kidney transplantation for individuals under age 21 in the Child Health Services (EPSDT) Program. These procedure codes include ~~48160, 48550~~ and ~~48554~~ through ~~48556~~. Procedure codes for allograft preparation are ~~48550~~ through ~~48552~~.

Pancreas/kidney transplantation procedure codes require prior approval. The appropriate code(s) may be billed in conjunction when performing the pancreas/kidney transplant procedure. This surgery will be treated as a multiple surgery and will be reimbursed accordingly.

292.824 Billing for Bone Marrow Transplants

1~~0~~-1-~~15~~221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. CPT procedure codes ~~38240, 38241~~ and ~~38243~~ are payable, with prior approval, for a bone marrow transplant. See Section 261.220 of this manual for prior approval information.

B. Harvesting procedure codes ~~38230~~ and ~~38231~~ do not require prior approval and must be used when billing for the donor.

C. All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

D. CPT procedure code ~~38232~~ requires an ICD diagnosis code of (**View ICD Codes.**).

1. No claims will be considered for payment after the 60 calendar days have elapsed.
2. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

292.825 Billing for Heart Transplants

~~3-15-05~~10-1-2~~1~~2

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code ~~33945~~ is payable for a heart transplant. This code requires prior approval.

292.826 Billing for Liver Transplants

~~3-15-05~~10-1-~~22~~1

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code ~~47135~~ is payable for a liver transplant. This code requires prior approval.

292.827 Billing for Liver/Bowel Transplants

10-1-06221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Liver/bowel transplant procedure codes require prior approval.

B. Procedure code 47135 is to be used for the liver.

C. Procedure codes 44135, 44136, 44132 and 44133 are to be used for the intestine, as applicable.

292.828 Billing for Lung Transplants

3-15-0510-1-221

Arkansas Medicaid covers lung transplants (single or double) for beneficiaries of all ages, if deemed medically necessary and prior approved. Use the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

32851	32852	32853	32854

292.831 Billing for Tissue Typing

3-15-0510-1-221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. CPT procedure codes 86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821 and 86822 are payable for the tissue typing for both the donor and the receiver.

B. The tissue typing is subject to the $500 annual lab and X-ray benefit limit.

1. Extensions will be considered for individuals who exceed the $500.00 annual lab and X-ray benefit limit.
2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue typing procedures to determine a match for an unrelated donor for a bone marrow transplant.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

292.840 Vascular Embolization and Occlusion

2-15-1510-1-221

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

37241	37242	37243	37244

292.850 Blood or Blood Components for Transfusions

~~7-1-07~~10-1-~~22~~1

The Arkansas Medicaid Program will reimburse for blood or blood components used for transfusions in the physician's office. CPT procedure code ~~36430~~ should be used for the administration fee. This includes all supplies used to perform the transfusion. The blood or blood components supplied by the physician may be billed using CPT procedure code ~~86999~~.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A copy of the invoice must be attached to the claim form with the amount that was charged for the blood product circled. The number of units provided to the Medicaid eligible patient must be indicated on the invoice. Any laboratory procedures performed may be billed using the appropriate CPT procedure codes.

292.860 Hyperbaric Oxygen Therapy (HBOT) Procedures

1~~0~~-1-~~09~~221

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy (HBOT). Physicians billing for the physician component of "Physician attendance and supervision of hyperbaric oxygen therapy" **may bill for only one unit of service per day.** The physician's charge for each service date must include all his or her hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Physicians may bill for surgery and professional components of anatomical lab procedures, X-rays and machine tests in addition to ~~99183~~.

B. Physicians may file paper or electronic claims for ~~99183~~ with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

NOTE: Refer to Section 258.000 of this manual for coverage policy, diagnosis requirements and treatment schedules.

292.880 Enterra Therapy for Gastroparesis

~~9-15-12~~10-1-~~22~~1

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

When filing claims for Enterra therapy for treatment of gastroparesis, use procedure code ~~64590~~ for implantation of gastric electrical stimulation and ~~64555~~ for implantation of peripheral neurostimulator electrodes. A prior authorization number is required on the claim.

Procedure code ~~64595~~ must be used when filing claims for revision or removal of the peripheral neurostimulator. This procedure does not require prior authorization but the claim must be filed on paper with operative report attached.

292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule

1~~0~~-1-~~15~~221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as ~~91110~~, is payable for all ages and must be billed with the primary detail diagnosis of (**View ICD Codes.**).

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

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

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

292.900 Tobacco Cessation Counseling Services ~~810~~-1-2~~21~~

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**

~~⁂~~**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~Current Procedure Code~~	~~Current Modifier~~	~~Arkansas Medicaid Description~~
~~99406*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intermediate, 15 minutes)~~
~~99406*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intermediate, 15 minutes provided to parents of children birth through twenty (20) years of age)~~
~~99407*~~	~~SE~~	~~⁂(Smoking and tobacco use cessation counseling visit; intensive, 30 minutes)~~
~~99407*~~	~~CG~~	~~⁂ (Smoking and tobacco use cessation counseling visit, intensive, 30 minutes provided to parents of children birth through twenty (20) years of age)~~

* Exempt from PCP referral.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count toward the four (4) counseling session limit described in section C above.

G. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**

Oral surgeons must use procedure code ~~D9920~~ for one 15-minute unit and procedure code ~~D1320~~ for one 30-minute unit when filing claims on the American Dental Association (ADA).

See Section 257.000 of this manual for coverage and benefit limit information.

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder ~~9-1-2010~~-1-22~~1~~

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate

   a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group who has at least one (1) performing provider with an X-DEA number on file with Arkansas Medicaid.

      i. For new patients, the provider group shall use HCPCS code ~~H0001~~, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

      ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code ~~H0001~~, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

      iii. For established patients requiring maintenance follow-up MAT treatment, the provider group shall use HCPCS code ~~H0001~~, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

      iv. The specific HCPCS code and modifiers found in the following link are required for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services**.

2. Method 2 – Regular Fee-for-Service Rates

   a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

      i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

      ii. For established patients requiring continuing treatment, the MAT provider shall

use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

iii. For established patients requiring maintenance treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: (**View ICD OUD Codes.**)

Allowable lab and screening codes may be found here: (**View Lab and Screening Codes**.)

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

292.940 Radiopharmaceutical Services 10-1-~~15~~221

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Prior Approval is required before services associated with the use of procedure codes ~~A9542, A9543, A9544~~ and ~~A9545~~ may be provided. To obtain a Prior Approval Letter from the Division of Medical Services Medical Director for Clinical Affairs, the provider must furnish the following documentation (See Section 244.100 and 292.595.):

1. The FDA approved diagnosis clearly stated
2. Treatment failures that the patient has previously experienced
3 The patient's history and physical report

Prior Approval is required before services associated with the use of procedure code ~~A9547~~ may be provided. To obtain Prior Approval, the provider must submit the following documentation:

1. The patient's history and physical
2. A report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic

Prior Approval is required for the service associated with the use of procedure code ~~A9555~~. To obtain Prior Approval, the provider must submit:

1. A history and physical
2. A report on what other profusion scans have been tried and are non-diagnostic

Some HCPCS laboratory and radiology services are payable only with diagnosis restrictions. For payment, these diagnoses must be entered on the claim.

~~Procedure Code~~	~~Age Restriction~~	~~Diagnosis~~	~~Special Criteria~~
~~A9557~~	~~No~~	~~View ICD Codes.~~	~~No~~
~~A9559~~	~~No~~	~~View ICD Codes.~~	~~No~~
~~A9563~~	~~No~~	~~View ICD Codes.~~	~~No~~

Procedure Code	Age Restriction	Diagnosis	Special Criteria
A9580*	No	View ICD Codes.	Manufacturer's Invoice
A9581	21y & up	No	No
A9582*	No	No	Manufacturer's Invoice
A9604	21y & up	List 003*	Manufacturer's Invoice

*List 003 diagnosis codes include (**View ICD Codes.**). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Radiopharmaceutical therapy is covered with prior approval from the Medical Director for Clinical Affairs of the Division of Medical Services. Claims must be filed using procedure code 79403.

1. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.
2. A copy of the Medical Director for Clinical Affair's approval letter and a copy of the invoice for the monoclonal antibody used must be attached to the claim form.

Refer to Section 244.200 for coverage information and instructions for requesting prior approval.

For coverage information regarding any drug not listed in Section 292.950, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

292.950 Injections, Therapeutic and/or Diagnostic Agents

5-1-17 10-1-22

A. 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 Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code, T1502 is payable for beneficiaries of all ages. T1502 mMay 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 cCannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

T1502 cCannot 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 cCannot be billed when the drug administered is not FDA approved.

See the table below when billing T1502:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure Code	Modifier	Eligibility Category

~~T1502~~	~~EP~~	~~ARKids A (Ages 0-20)~~
~~T1502~~	~~SL~~	~~ARKids B~~
~~T1502~~		~~Ages 19 and above~~

Most of the covered drugs can be billed electronically. **However, any covered 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 for manually priced drugs is based on a percentage of the average wholesale price.

See Section 292.940 for coverage information of radiopharmaceutical procedure codes.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 292.910 for further information.

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 form. 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 payable CPT code ranges ~~**96365** through **96379** and **96401** through **96549**~~ for therapeutic and chemotherapy administration procedure codes.

See Section 292.940 for radiopharmaceutical drugs.

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
3. All other billing requirements must be met in order for payment to be approved.

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.** See Section 292.950 for covered vaccines and billing protocols.

Coverage criteria for all immunizations and vaccines are listed in Part F of this section.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and obviously which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. **Vaccines for Children (VFC)**

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

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

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information**.

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables section of this manual. See Part F of this section.

E. **Billing of Multi-Use and Single-Use Vials**

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

1. 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 payable CPT code ranges ~~96365 through 96379~~.
2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
    a. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
    b. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
    c. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
    d. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e. for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 292.910 for additional information regarding National Drug Code (NDC) billing.

F. **Tables of Payable Procedure Codes**

The tables of payable procedure codes are designed with eight columns of information.

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
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(y) or months (m).
4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)

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

In collaboration with AFMC, DMS has changed 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. 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.

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 **https://afmc.org.reviewpoint/ (View or print PA form.)**

A decision letter will be returned to the provider by fax or *e* 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.

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.

H. 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:

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.reviewpoint/**
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

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

~~*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)~~

~~See Sections 261.000 – 261.220 for prior authorization procedures.~~

~~See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.~~

~~List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)~~
~~Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.~~

~~Procedure Code~~	~~Modifier~~	~~Age Restriction~~	~~Diagnosis~~	~~Diagnosis List~~	~~Review~~	~~PA~~
~~A9520~~	~~No~~	~~18y & up~~	~~**View ICD Codes.**~~	~~No~~	~~No~~	~~No~~

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
A9575	No	2y & up	No	No	No	No
A9580*	No	No	**View ICD Codes.**	No	No	No

NOTE: Procedure code A9580 is payable for beneficiaries with a primary diagnosis of (**View ICD Codes.**). Requires a paper claim with manufacturer's invoice identifying the cost of the radiopharmaceuticals.

A9585	No	2y & up	No	No	No	No
A9586	No	18y & up	**View ICD Codes.**	No	No	No
C9132	No	18y & up	**View ICD Codes.**	No	Yes	No

NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9248	No	No	No	No	No	No
C9254	No	No	No	No	No	No
C9257	No	21y & up	Yes	No	No	Yes

NOTE: Coverage of procedure code C9257 is for ages 21 years and above with any of these diagnosis codes (**View ICD Codes.**). Documentation included with Prior Approval Letter request must include Fluorescein angiogram or OCT, patient screen for conditions that would contraindicate the use of **Avastin**, and documentation of patient consent.

C9460	No	No	No	No	No	Yes

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.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
C9739	No	No	No	No	No	No
NOTE: Covered for makes only.						
C9740	No	No	No	No	No	No
NOTE: Covered for makes only.						
G6015	No	No	No	No	No	No
J0120	No	No	No	003	No	No
J0129	No	No	No	No	No	Yes
NOTE: 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.						
J0133	No	No	**View ICD Codes.**	No	No	No
J0150	No	No	No	No	No	No
NOTE: Maximum units allowed are 4 per day.						
J0151	No	No	No	No	No	No
J0153	No	No	No	No	No	No
J0171	No	No	No	No	No	No
J0178	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: **Eylea** should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with **Eylea** injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.						
J0180	No	No	No	No	No	Yes
NOTE: Procedure code J0180 is covered for treatment of Fabry's disease, with an ICD diagnosis code of (**View ICD Codes.**).						
J0190	No	No	No	003/103	No	No
J0202	No	No	No	No	No	No
J0205	No	No	No	003/103	No	No
J0207	No	No	No	003/103	No	No
J0210	No	No	No	003/103	No	No
J0220	No	No	No	No	No	Yes
NOTE: Evaluation by a physician with a specialty in clinical genetics documenting progress required annually.						
J0221	No	No	No	No	No	Yes
NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile, Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme ACE Program. The history and physical should document compliance with this program including discussion of the risks of anaphylaxis, severe allergic reactions and immune-mediated reactions according to the Black Box Warning from the FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0256	No	No	**View ICD Codes.**	No	No	No
J0257	No	18y & up	**View ICD Codes.**	No	No	No

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1-proteinase must be clearly documented in the chart. Alpha 1-antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30 – 65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha 1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003/103	No	No
J0280	No	No	No	003/103	No	No
J0285	No	No	No	003/103	No	No
J0287	No	No	No	003/103	No	No
J0288	No	No	No	003/103	No	No
J0289	No	No	No	003/103	No	No
J0290	No	No	No	003/103	No	No
J0295	No	No	No	003/103	No	No
J0300	No	No	No	003/103	No	No
J0330	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0348	No	No	Yes	003/103	No	No
NOTE: Procedure code J0348 is valid for any condition below, along with an ICD diagnosis code of (**View ICD Codes.**): (1) End-stage Renal Disease or (2) AIDS or Cancer or (3) Post transplant status or specify transplanted organ and transplant date.						
J0350	No	No	No	003/103	No	No
J0360	No	No	No	003/103	No	No
J0380	No	No	No	003/103	No	No
J0390	No	No	No	003/103	No	No
J0401	No	13y & up	**View ICD Codes.**	No	No	No
J0456	No	No	No	003/103	No	No
J0461	No	No	No	003/103	No	No
J0470	No	No	No	003/103	No	No
J0475	No	No	No	No	No	No
J0476	No	No	No	No	No	No
J0480	No	No	**View ICD Codes.**	No	No	No
J0485	No	18y & up	**View ICD Codes.**	No	No	No
J0490	No	18y & up	**View ICD Codes.**	No	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.						
J0500	No	No	No	003/103	No	No
J0515	No	No	No	003/103	No	No
J0520	No	No	No	003/103	No	No
J0558	No	No	No	003/103	No	No
J0561	No	No	No	003/103	No	No
J0585	No	No	No	No	Yes	No
NOTE: Botox A is reviewed for medical necessity based on ICD diagnosis code.						
J0586	No	No	No	No	Yes	No
NOTE: This procedure code is reviewed for medical necessity based on an ICD diagnosis code billed.						
J0588	No	18y & up	No	No	Yes	No
NOTE: An ICD diagnosis code which supports medical necessity is required.						
J0592	No	No	No	003/103	No	No
J0595	No	No	No	003/103	No	No
J0596	No	13y & up	**View ICD Codes**	No	Yes	No
J0600	No	No	No	003/103	No	No
J0610	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0620	No	No	No	003/103	No	No
J0630	No	No	No	003/103	No	No
J0636	No	No	**View ICD Codes.**	No	No	No
J0637*	No	No	No	No	Yes	No
NOTE: Procedure code J0637 is 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.						
J0638	No	4y &up	**View ICD Codes.**	No	No	No
J0640	No	No	No	003/103	No	No
J0641	No	No	No	No	Yes	No
NOTE: Approved Only: 1. After high methotrexate therapy in osteosarcoma or 2. To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.						
J0670	No	No	No	003/103	No	No
J0690	No	No	No	003/103	No	No
J0692	No	No	No	003/103	No	No
J0694	No	No	No	003/103	No	No
J0695	No	18y & up	No	No	No	No
J0696	No	No	No	003/103	No	No
J0697	No	No	No	003/103	No	No
J0698	No	No	No	003/103	No	No
J0702	No	No	Yes	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Procedure code J0702 is covered for a valid diagnosis code (**View ICD Codes.**) for complications of pregnancy or List 003 for all ages.						
J0706	No	No	No	003/103	No	No
J0710	No	No	No	003/103	No	No
J0712	No	18y & up	No	No	No	No
J0713	No	No	No	003/103	No	No
J0714	No	18y & up	No	No	No	No
J0715	No	No	No	003/103	No	No
J0716	No	No	**View ICD Codes.**	No	No	No
J0717	No	No	**View ICD Codes.**	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (**Cimzia**) for adult beneficiaries 18 years of age and above with: 1. Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms: Diarrhea Internal fistulae Abdominal pain Intestinal obstruction Bleeding Extra-intestinal manifestations Weight loss Arthritis Perianal disease Spondylitis **and** Crohn's disease has remained active despite treatment with corticosteroids or 6-mercaptopurine/azathioprine. **or** 2. For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed **Enbrel** and **Humira**.						
J0720	No	No	No	003/103	No	No
J0725	No	No	No	003/103	No	No
J0735	No	No	No	003/103	No	No
J0740	No	No	No	003/103	No	No
J0743	No	No	No	003/103	No	No
J0744	No	No	No	003/103	No	No
J0745	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0760	No	No	No	003/103	No	No
J0770	No	No	No	003/103	No	No
J0780	No	No	No	003/103	No	No
J0795	No	No	No	003/103	No	No
J0800	No	No	No	003/103	No	No
J0833	No	No	No	No	No	No
J0834	No	No	No	No	No	No
J0850	No	No	No	003/103	No	No
J0875	No	18y & up	No	No	No	No
J0881 J0885	No	No	Yes; see below	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA

NOTE: For patients on dialysis, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

When the beneficiary is not on dialysis, use ICD code (**View ICD Codes.**).

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

Column I	**Column II**	
	Code	**Description**
Secondary Anemia (**View ICD codes.**)	**View ICD Codes:**	Encounter for antineoplastic chemotherapy
	View ICD Codes:	Following chemotherapy
	View ICD Codes:	Antineoplastic and immunosuppressive drugs

Use ICD code (**View ICD Codes.**) (primary) with (**View ICD Codes.**) (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.

Column I	**Column II**	
	Code	**Description**
Anemia of other	**View**	Chronic Hepatitis C

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0882	No	No	**View ICD Codes.**	No	No	No
J0885						
NOTE: See procedure code J0881 in this section for specific criteria.						
J0886	No	No	**View ICD Codes.**	No	No	No
J0887	No	21y & up	Yes; see below	No	No	Yes
NOTE: The primary diagnosis should be (**View ICD Codes.**) with a secondary diagnosis of (**View ICD Codes.**). For patients with CKD **on dialysis**: Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL. If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera. The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic. Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every two-week dose and subsequently titrated as necessary						
J0888	No	21y & up	**View ICD Codes**	No	No	No
NOTE: For patients with CKD **not on dialysis**: Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply: The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J0894	No	No	**View ICD Codes.**	No	No	Yes
J0895	No	No	No	No	No	No
J0897	No	18y & up	Yes	No	Yes	Yes

NOTE: **Prolia Policy**: Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (**View ICD Codes.**). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for Prolia. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (**View ICD Codes.**) or adjuvant aromatase inhibitor therapy for breast cancer (**View ICD Codes.**). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 on a paper claim with the drug name and dose. Xgeva is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. Xgeva is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. Xgeva requires documentation in the medical record of the rationale for why Zometa was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record. The NDC for the drug requested must be listed on the request.

J0945	No	No	No	003/103	No	No
J1000	No	No	No	003/103	No	No
J1020	No	No	No	003/103	No	No
J1030	No	No	No	003/103	No	No
J1040	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1050	^	10y & up	^	No	No	No
^ J1050 is covered for therapeutic and family planning services for females only. For therapeutic use, a diagnosis and clinical records must justify the treatment. When billed for family planning, a FP modifier and an ICD family planning diagnosis is required. NOTE: Relative to post occlusion by placement of permanent implants; procedure codes J1050, 11976 and 58301 are payable family planning services for non-sterile females only. All visits related to post-58565 services during the six months following the procedure are included in the allowable fee for the 58565 "procedure." All facility fees for J1050 are bundled under the surgical procedure code if performed on the same date of service.						
J1071	No	No	No	003/103	No	No
J1094	No	No	No	003/103	No	No
J1100	No	No	Yes	003/103	No	No
NOTE: Procedure code J1100 is covered for a valid diagnosis code from the following range of ICD codes (**View ICD Codes.**) for complications of pregnancy or List 003 for all ages.						
J1110	No	No	No	003/103	No	No
J1120	No	No	No	003/103	No	No
J1160	No	No	No	003/103	No	No
J1165	No	No	No	003/103	No	No
J1170	No	No	No	003/103	No	No
J1180	No	No	No	003/103	No	No
J1190	No	No	No	003/103	No	No
J1200	No	No	No	003/103	No	No
J1205	No	No	No	003/103	No	No
J1212	No	No	No	003/103	No	No
J1230	No	No	No	003/103	No	No
J1240	No	No	No	003/103	No	No
J1245	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1250	No	No	No	003/103	No	No
J1260	No	No	No	003/103	No	No
J1267	No	No	No	003/103	No	No
J1270	No	No	Yes	003/103	No	No
NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below : A valid ICD diagnosis from list 003 or a valid ICD code of the following renal failure code range (**View ICD Codes.**). **Plus** an ICD diagnosis from the following code range (**View ICD Codes.**). **Plus** an ICD diagnosis of (**View ICD Codes.**).						
J1300	No	No	**View ICD Codes.**	No	No	Yes
J1320	No	No	No	003/103	No	No
J1325	No	No	No	003/103	No	No
J1330	No	No	No	003/103	No	No
J1335	No	No	No	003/103	No	No
J1364	No	No	No	003/103	No	No
J1380	No	No	No	003/103	No	No
J1410	No	No	No	003/103	No	No
J1435	No	No	No	003/103	No	No
J1436	No	No	No	003/103	No	No
J1439	No	18y & up	**View ICD Codes**	No	No	No
J1442	No	No	No	No	No	No
J1443	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1447	No	No	No	No	No	Yes
J1450	No	No	No	003/103	No	No
J1452	No	No	No	003/103	No	No
J1453	No	No	No	003/103	No	No
J1455	No	No	No	003/103	No	No
J1457	No	No	No	003/103	No	No
J1458	No	No	No	No	No	Yes
J1459	No	16y & up	No	No	No	No
J1460	No	No	No	No	No	No
J1556	No	6y & up	No	No	Yes	Yes
NOTE: **Bivigam** is an immune globulin intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.						
J1557	No	2y & up	No	No	Yes	No
NOTE: An ICD diagnosis code that supports medical necessity is required.						
J1559	No	4y & up	**View ICD Codes.**	No	No	No
J1560	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1562	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1568	No	No	No	No	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1569	No	No	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1570	No	No	No	003/103	No	No
J1575	No	18y & up	No	No	Yes	No
J1580	No	No	No	003/103	No	No
J1590	No	No	No	003/103	No	No
J1599	No	4y & up	No	No	Yes	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.						
J1600	No	No	**View ICD Codes.**	No	No	No
J1602	No	18y & up	No	No	Yes	Yes

NOTE: **Simponi** is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.

Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.

Active ankylosing spondylitis that has failed **Humira** and **Enbrel**.

Moderate to severe ulcerative colitis that has failed **Humira**.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J1610	No	No	No	003/103	No	No
J1620	No	No	No	003/103	No	No
J1626	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1630	No	No	No	003/103	No	No
J1631	No	No	No	003/103	No	No
J1640	No	No	**View ICD Codes.**	No	No	No
J1642	No	No	No	003/103	No	No
J1644	No	No	No	003/103	No	No
J1645	No	No	No	003/103	No	No
J1650	No	No	No	No	No	No
J1652	No	No	No	No	No	No
J1655	No	No	No	003/103	No	No
J1670	No	No	No	003/103	No	No
J1700	No	No	No	003/103	No	No
J1710	No	No	No	003/103	No	No
J1720	No	No	No	003/103	No	No
J1725	No	16y & up	**View ICD Codes.**	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (**View ICD Codes.**), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003/103	No	No
J1740	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1741	No	18y & up	No	No	No	No
J1742	No	No	No	003/103	No	No
J1743	No	No	No	No	No	Yes
NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.						
J1745	No	No	Yes	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis code is (**View ICD Codes.**). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years require a Prior Approval Letter. For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist: Use an ICD diagnosis code of (**View ICD Codes.**) as the primary detail diagnosis **AND** a secondary diagnosis of (**View ICD Codes.**). OR (**View ICD Codes.**) OR (**View ICD Codes.**) OR (**View ICD Codes.**) ICD diagnosis code (**View ICD Codes.**) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**. Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment. OR (**View ICD Codes.**) ICD diagnosis code (**View ICD Codes.**) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**. Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.						
J1750	No	No	No	No	No	No
J1756	No	18y & up	No	No	No	Yes
J1786	No	2y & up	**View ICD Codes.**	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J1790	No	No	No	003/103	No	No
J1800	No	No	No	003/103	No	No
J1810	No	No	No	003/103	No	No
J1815	No	No	No	003/103	No	No
J1830	No	No	No	003/103	No	No
J1833	No	18y & up	No	No	No	No
J1835	No	No	No	003/103	No	No
J1840	No	No	No	003/103	No	No
J1850	No	No	No	003/103	No	No
J1885	No	No	No	003/103	No	No
J1890	No	No	No	003/103	No	No
J1930	No	No	No	No	No	No
J1931	No	No	**View ICD Codes.**	No	No	Yes
J1940	No	No	No	003/103	No	No
J1950	No	No	No	003/103	No	No
J1953	No	17y & up	No	No	No	No
J1955	No	No	No	003/103	No	No
J1956	No	No	No	003/103	No	No
J1960	No	No	No	003/103	No	No
J1980	No	No	No	003/103	No	No
J1990	No	No	No	003/103	No	No
J2001	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2010	No	No	No	003/103	No	No
J2020	No	No	No	003/103	No	No
J2060	No	No	No	003/103	No	No
J2150	No	No	No	003/103	No	No
J2175	No	No	No	003/103	No	No
J2180	No	No	No	003/103	No	No
J2185	No	No	No	003/103	No	No
J2210	No	No	No	003/103	No	No
J2248	No	No	No	No	No	No
J2250	No	No	No	003/103	No	No
J2260	No	No	**View ICD Codes.**	No	No	No
J2270	No	No	No	003/103	No	No
J2271	No	No	No	003/103	No	No
J2274	No	No	No	No	No	No
J2275	No	No	No	003/103	No	No
J2278	No	No	No	003/103	No	No
J2280	No	No	No	003/103	No	No
J2300	No	No	No	003/103	No	No
J2310	No	No	No	003/103	No	No
J2320	No	No	No	003/103	No	No
J2323	No	No	No	No	No	Yes
NOTE: The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the Prior Approval Letter.						
J2353	No	No	No	003/103	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2354	No	No	No	003/103	Yes	Yes
NOTE: A Prior Approval Letter is required for a diagnosis other than a List 003 diagnosis.						
J2355	No	No	No	003/103	No	No
J2358	No	18y & up	No	003/103	No	No
J2360	No	No	No	003/103	No	No
J2370	No	No	No	003/103	No	No
J2400	No	No	No	003/103	No	No
J2405	No	No	No	003/103	No	No
J2407	No	18y & up	No	No	No	No
J2410	No	No	No	003/103	No	No
J2425	No	No	No	003/103	No	No
J2426	No	18y & up	**View ICD Codes.**	No	No	No
J2430	No	No	No	003/103	No	No
J2440	No	No	No	003/103	No	No
J2460	No	No	No	003/103	No	No
J2469	No	No	No	003/103	No	No
J2501	No	No	No	No	No	No
J2503	No	No	**View ICD Codes.**	No	No	No
J2504	No	No	**View ICD Codes.**	No	No	No
J2505	No	No	Yes	003/103	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Procedure code J2505 is payable for beneficiaries of all ages with a detail diagnosis code (**View ICD Codes.**). Diagnosis codes (**View ICD Codes.**) are covered along with a diagnosis of AIDS or cancer (List 003). Diagnosis codes must be shown on the claim form.						
J2507	No	18y & up	No	No	No	Yes
NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.						
J2510	No	No	No	003/103	No	No
J2513	No	No	No	No	No	No
J2515	No	No	No	003/103	No	No
J2540	No	No	No	003/103	No	No
J2543	No	No	No	003/103	No	No
J2547	No	18y & up	**View ICD Codes**	No	No	No
J2550	No	No	No	003/103	No	No
J2560	No	No	No	003/103	No	No
J2562	No	21y & up	No	No	No	Yes
NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). Prior authorization will be provided by a telephone review. Approval is granted in conjunction with the use of granulocyte-colony stimulating factor to mobilize hematopoietic stem cells for collection and subsequent autologous transplantation in patients with Non-Hodgkin's lymphoma and multiple myeloma. Applicants will only be considered for approval if a transplant has been approved by AFMC. There must be documentation of failure to mobilize cells with conventional therapy for consideration of this drug. The drug will only be approved for four doses; one daily, times four days. The total dosage for the four days must be indicated at the time of the request.						
J2590	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J2597	No	No	No	No	No	No
J2650	No	No	No	003/103	No	No
J2670	No	No	No	003/103	No	No
J2675	No	No	No	003/103	No	No
J2680	No	No	No	003/103	No	No
J2690	No	No	No	003/103	No	No
J2700	No	No	No	003/103	No	No
J2710	No	No	No	003/103	No	No
J2720	No	No	No	003/103	No	No
J2725	No	No	No	003/103	No	No
J2730	No	No	No	003/103	No	No
J2760	No	No	No	003/103	No	No
J2765	No	No	No	003/103	No	No
J2770	No	No	No	003/103	No	No
J2778	No	No	No	No	Yes	Yes
J2780	No	No	No	003/103	No	No
J2783	No	No	No	003/103	No	No
J2788	No	No	No	No	No	No
J2790	No	No	No	No	No	No
J2791	No	No	No	No	No	No
J2792	No	No	No	No	No	No
J2796	No	19y & up	View ICD Codes.	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Beneficiaries must have failed corticosteroids, immunoglobulins or have had a splenectomy. Beneficiaries must have thrombocytopenia and a clinical condition that causes increased risk of bleeding. **Romiplostim** is not to be used to normalize platelet counts.						
J2800	No	No	No	003/103	No	No
J2820	No	No	No	003/103	No	No
J2860	No	No	No	No	No	Yes
J2910	No	No	**View ICD Codes.**	No	No	No
J2916	No	No	No	No	No	No
J2920	No	No	No	003/103	No	No
J2930	No	No	No	003/103	No	No
J2941	No	No	No	003/103	No	No
J2950	No	No	No	003/103	No	No
J2993	No	No	No	No	No	No
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (**View ICD Codes.**) on the claim.						
J2995	No	No	No	003/103	No	No
J2997	No	No	No	No	No	No
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (**View ICD Codes.**) on the claim.						
J3000	No	No	No	003/103	No	No
J3010	No	No	No	003/103	No	No
J3030	No	No	No	003/103	No	No
J3060	No	18y & up	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A complete history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.						
J3070	No	No	No	003/103	No	No
J3090	No	18y & up	No	No	No	No
J3095	No	18y & up	No	003/103	No	No
J3105	No	No	No	003/103	No	No
J3120	No	No	No	003/103	No	No
J3121	No	No	No	003/103	No	No
NOTE: Covered for males only.						
J3130	No	No	No	003/103	No	No
J3145	No	No	No	003/103	No	No
NOTE: Covered for males only.						
J3230	No	No	No	003/103	No	No
J3240	No	No	No	003/103	No	No
J3250	No	No	No	003/103	No	No
J3260	No	No	No	003/103	No	No
J3262	No	18y & up	No	No	No	Yes
NOTE: The patient must have tried and failed therapy with documented progression of symptoms on **Humira** and **Enbrel** prior to the request for this drug. The physician medical record must document a history and physical examination that clearly shows failure of **Humira** and **Enbrel** with submission for a prior approval letter. Doses exceeding 800 mg per infusion will not be approved, as they are not recommended. The physician must follow all Food and Drug Administration (FDA) recommendations on monitoring of laboratory and serious infections.						
J3265	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3280	No	No	No	003/103	No	No
J3300	No	No	No	No	No	No
J3301	No	No	No	003/103	No	No
J3302	No	No	No	003/103	No	No
J3303	No	No	No	003/103	No	No
J3305	No	No	No	003/103	No	No
J3310	No	No	No	003/103	No	No
J3315	No	No	No	003/103	No	No
J3320	No	No	No	003/103	No	No
J3350	No	No	No	003/103	No	No
J3357	No	18y & up	No	No	No	Yes

NOTE: There must be clear documentation that the patient has failed **Humira** and **Enbrel**, with documentation of progression of the disease or documented inability to tolerate **Humira** and **Enbrel**. A physician history and physical must be submitted with a request for prior approval letter. Documentation of patient counseling of the adverse effects of the drug should also be included. This drug should only be administered to patients who will be closely monitored and have regular follow-up visits by a physician.

J3360	No	No	No	003/103	No	No
J3364	No	No	No	003/103	No	No
J3365	No	No	No	003/103	No	No
J3370	No	No	No	003/103	No	No
J3380	No	18y – 99y	No	No	No	Yes
J3385	No	4y & up	No	No	Yes	Yes

NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. A history and physical exam by a geneticist is required yearly for approval. The history and physical exam should document the prognosis of the patient as well as current symptoms.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J3396	No	No	**View ICD Codes.**	No	Yes	No
J3400	No	No	No	003/103	No	No
J3410	No	No	No	003/103	No	No
J3420	No	No	**View ICD Codes.**	No	No	No
J3430	No	No	No	003/103	No	No
J3465	No	No	No	No	No	No
NOTE: Procedure code J3465 is covered for non-pregnant beneficiaries.						
J3470	No	No	No	003/103	No	No
J3475	No	No	No	003/103	No	No
J3480	No	No	No	003/103	No	No
J3485	No	No	No	003/103	No	No
J3489	No	No	**View ICD Codes.**	No	No	No
J3490*	U9	16y & up	**View ICD Codes.**	No	No	No
NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (**View ICD Codes.**), "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."						
J3520	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7121	No	No	No	No	No	No
J7178	No	No	**View ICD Codes.**	No	No	No
J7180	No	2y & up	**View ICD Codes.**	No	No	No
J7181	No	No	**View ICD Codes**	No	No	No
J7183	No	No	**View ICD Codes.**	No	No	No
J7185	No	21y – 65y	No	No	No	No
J7186	No	No	No	No	No	No
J7187	No	No	No	No	No	No
J7188	No	No	No	No	No	Yes
J7190	No	No	No	No	No	No
J7191	No	No	No	No	No	No
J7192	No	No	No	No	No	No
J7193	No	No	No	No	No	No
J7194	No	No	No	No	No	No
J7195	No	No	No	No	No	No
J7196	No	18y & up	**View ICD Codes.**	No	No	No
J7197	No	No	No	No	No	No
J7198	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7199*	No	No	No	No	No	No
J7201	No	No	No	No	No	No
J7205	No	No	No	No	No	Yes
J7297	FP	12y – 65y	No	No	No	No
NOTE: J7297 with and FP modifier requires a primary diagnosis of family planning on the claim.						
J7298* Females Only	No	12y – 65y	No	**View ICD Codes**	No	No
J7298* Females Only	FP	12y – 65	No	No	No	No
NOTE J7298 with an FP modifier requires a primary diagnosis of family planning on the claim.						
J7300	FP	No	No	No	No	No
NOTE: Procedure code J7300 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.						
J7301	FP	10y & up	No	No	No	No
NOTE: Procedure code J7301 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.						
J7303	FP	No	No	No	No	No
NOTE: Procedure code J7303 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.						
J7306	FP	No	No	No	No	No
NOTE: Procedure code J7306 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.						
J7307	FP	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Procedure code J7307 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.						
J7308	No	No	No	003	No	No
J7310	No	No	No	003	No	Yes
J7312	No	No	No	No	No	Yes
NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method. There should be documentation of vein occlusion and studies documenting macular edema. Visual acuity should be noted after the vein occlusion or after failed treatments for uveitis. The patients should be monitored after the injection for elevation in intraocular pressure and endophthalmitis. Counseling of side effects should be documented in the medical record. The history and physical exam including all tests should be sent with the request for prior approval letter.						
J7313	No	No	No	No	No	Yes
J7316	No	No	No	No	No	Yes
NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.						
J7321	No	No	No	No	No	Yes
J7323	No	No	No	No	No	Yes
J7324	No	No	No	No	No	Yes
J7325	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 261.200 for Utilization Review prior authorization information. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. **Hyaluronon** is limited to one injection or series of injections per knee, per beneficiary, per lifetime. A maximum of three injections per knee are allowed of **Hylan** polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures. Refer to Section 261.200 for Prior Authorization.						
J7327	No	No	No	No	No	Yes
J7328	No	No	No	No	No	Yes
J7330	No	No	No	No	No	Yes
NOTE: Procedure code J7330 requires prior authorization from AFMC for all providers. See Sections 260.000, 261.000, 261.100 and 261.110.						
J7501	No	No	No	003/103	No	No
J7502	No	No	No	No	No	No
J7504	No	No	No	003/103	No	No
J7505	No	No	No	003/103	No	No
J7506	No	No	No	003/103	No	No
J7507	No	No	No	003/103	No	No
J7508	No	No	**View ICD Codes.**	No	No	No
J7509	No	No	No	003/103	No	No
J7510	No	No	No	003/103	No	No
J7511	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J7513	No	No	No	003/103	No	No
J7515	No	No	No	No	No	No
J7516	No	No	No	No	No	No
J7517	No	No	No	No	No	No
J7518	No	No	No	003/103	No	No
J7520	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No
NOTE: For consideration, procedure code J7525 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.						
J7527	No	18y & up	**View ICD Codes.**	No	No	No
J7599*	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.						
J8530	No	No	No	003/103	No	No
J8650*	No	No	No	No	No	No
J8705	No	No	No	003/103	No	No
J9000	No	No	No	003/103	No	No
J9010	No	No	No	003/103	No	No
J9015	No	No	No	003/103	No	No
J9017	No	No	No	003/103	No	No
J9019	No	2y – 18y	No	No	Yes	No
J9020	No	No	No	003/103	No	No
J9025	No	No	**View ICD Codes.**	No	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9031	No	No	No	003/103	No	No
J9032	No	No	No	No	No	Yes
J9033	No	No	No	No	No	Yes
J9035	No	No	No	No	No	Yes
J9039	No	No	No	No	No	Yes
J9040	No	No	No	003/103	No	No
J9041	No	No	No	No	No	Yes
J9042	No	18y & up	No	No	No	Yes

NOTE: **Adcetris** – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma diagnosis (**View ICD Codes.**) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043	No	18y & up	**View ICD Codes.**	No	No	Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with docetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003/103	No	No
J9047	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.						
J9050	No	No	No	003/103	No	No
J9055	No	No	No	No	No	Yes
J9060	No	No	No	003/103	No	No
J9065	No	No	No	003/103	No	No
J9070	No	No	No	003/103	No	No
J9098	No	No	No	003/103	No	No
J9100	No	No	No	003/103	No	No
J9120	No	No	No	003/103	No	No
J9130	No	No	No	003/103	No	No
J9150	No	No	No	003/103	No	No
J9151	No	No	No	003/103	No	No
J9155	No	21y & up	No	003/103	No	No
J9160	No	No	No	No	No	Yes
J9165	No	No	No	003/103	No	No
J9171	No	No	No	003/103	No	No
J9178	No	No	No	003/103	No	Yes
J9179	No	18y & up	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.						
J9181	No	No	No	003/103	No	No
J9185	No	No	No	003/103	No	No
J9190	No	No	No	003/103	No	No
J9200	No	No	No	003/103	No	No
J9201	No	No	No	003/103	No	No
J9202	No	No	No	003/103	No	No
J9206	No	No	No	003/103	No	No
J9207	No	No	No	No	No	Yes
J9208	No	No	No	003/103	No	No
J9209	No	No	No	003/103	No	No
J9211	No	No	No	003/103	No	No
J9212	No	No	No	003/103	No	No
J9213	No	No	No	003/103	No	No
J9214	No	No	No	003/103	No	No
J9215	No	No	No	003/103	No	No
J9216	No	No	No	003/103	No	No
J9217	No	No	No	003/103	No	No
J9218	No	No	No	003/103	No	No
J9219	No	No	**View ICD Codes.**	No	No	No
NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
J9225	No	No	**View ICD Codes.**	No	No	No
J9226	No	No	No	No	No	Yes

NOTE: **Supprelin LA**: Prior to initiation of treatment, a clinical diagnosis of CPP (**View ICD Codes.**) 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.

J9228*	No	18y & up	**View ICD Codes.**	No	Yes	No

NOTE: **Ipilmumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

J9230	No	No	No	003/103	No	No
J9245	No	No	No	003/103	No	No
J9250	No	No	No	No	No	No
J9260	No	No	No	003/103	No	No
J9261	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: The disease must have not responded to or has relapsed following treatment with at least 2 chemotherapy regimens.						
J9262	No	18y & up	No	No	No	Yes
NOTE: **Synribo** is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.						
J9263	No	No	No	No	No	Yes
J9264	No	No	No	No	No	Yes
J9265	No	No	No	003/103	No	No
J9266	No	No	No	003/103	No	No
J9268	No	No	No	003/103	No	No
J9270	No	No	No	003/103	No	No
J9271	No	No	No	No	No	Yes
J9280	No	No	No	003/103	No	No
J9293	No	No	Yes	No	Yes	No
NOTE: Requires ICD diagnosis code for cancer or ICD diagnosis code of (**View ICD Codes.**).						
J9299	No	No	No	No	No	Yes
J9300	No	No	No	003/103	No	No
J9301	No	No	No	No	No	Yes
J9302	No	No	No	No	No	Yes
J9303	No	No	No	No	No	Yes
J9305	No	No	No	No	No	Yes
J9306	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: **Perjeta** is an agent for the treatment of adults, age 18 – 99 years old, that is a Her2/neu receptor antagonist indicated in combination with trastuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.						
J9307	No	No	No	003/103	No	No
J9310	No	No	No	003/103	No	No
J9315	No	18y & up	No	003/103	No	No
J9320	No	No	No	003/103	No	No
J9328	No	No	No	No	No	Yes
NOTE: The diagnosis must be for: Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy OR As maintenance treatment for refractory anaplastic astrocytoma in patients who have disease progression on nitrosourea and procarbazine						
J9330	No	21y & up	**View ICD Codes.**	No	No	No
J9340	No	No	No	003/103	No	No
J9351	No	18y & up	No	003/103	No	No
J9354	No	No	No	No	No	Yes

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **trastuzumab** and a **taxane**, separately or in combination. Patients should have either: 1. received prior therapy for metastatic disease, **or** 2. developed disease recurrence during or within six months of completing adjuvant therapy. All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.						
J9355	No	No	No	003/103	No	No
J9357	No	No	No	003/103	No	No
J9360	No	No	No	003/103	No	No
J9370	No	No	No	003/103	No	No
J9371	No	No	No	No	No	Yes
NOTE: **Marqibo** is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.						
J9390	No	No	No	003/103	No	No
J9395	No	No	**View ICD Codes.**	No	Yes	No
J9400	No	No	No	No	No	Yes
NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.						
J9600	No	No	No	003/103	No	No
J9999	No	No	No	003/103	Yes	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

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See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: See Section 292.950 B for coverage information.						
P9041	No	No	No	No	No	No
P9045	No	No	No	No	No	No
P9046	No	No	No	No	No	No
P9047	No	No	No	No	No	No
Q0139	No	No	**View ICD Codes.**	No	No	No
Q0162	UB	4y & up	No	No	No	No
NOTE: Q0162 – UB represents "Ondansetron 1 mg, oral" billable electronically or on paper.						
Q0166	UB	No	No	003/103	No	No
NOTE: Use UB modifier for Q0166 – "Granistron HCl tab1mg, oral" (**Kytril**). This is the Arkansas Medicaid description.						
Q2009	No	No	No	003/103	No	No
Q2017	No	No	No	003/103	No	No
Q2034	No	18y & up	No	No	No	No
Q2043	No	No	No	No	No	Yes
NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.						
Q2049	No	18y & up	No	003/103	No	No
Q2050	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
Q3027	No	18y & up	**View ICD Codes.**	No	No	No
Q4081	No	No	**View ICD Codes.**	No	No	No
Q4121	No	No	No	No	No	No
Q4124	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.						
Q4145*	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice attached.						
Q4150	No	No	No	No	No	No
Q4152	No	No	No	No	No	No
Q4157	No	No	No	No	No	No
Q4160	No	No	No	No	No	No
Q5101	No	No	No	No	No	Yes
Q9969	No	No	No	No	No	No
Q9980	No	No	No	No	No	Q9980
S0017	No	No	No	003/103	No	No
S0021	No	No	No	003/103	No	No
S0023	No	No	No	003/103	No	No
S0028	No	No	No	003/103	No	No
S0030	No	No	No	003/103	No	No
S0032	No	No	No	003/103	No	No
S0034	No	No	No	003/103	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
S0039	No	No	No	003/103	No	No
S0040	No	No	No	003/103	No	No
S0073	No	No	No	003/103	No	No
S0074	No	No	No	003/103	No	No
S0077	No	No	No	003/103	No	No
S0080	No	No	No	003/103	No	No
S0081	No	No	No	003/103	No	No
S0092	No	No	No	003/103	No	No
S0093	No	No	No	003/103	No	No
S0108	No	No	No	003/103	No	No
S0119	No	4y & up	No	No	No	No
S0145	No	No	**View ICD Codes.**	No	No	No
S0164	No	No	No	003/103	No	No
S0177	No	No	No	003/103	No	No
S0179	No	No	No	003/103	No	No
S0187	No	No	No	003/103	No	No
90284	No	No	No	No	Yes	No
NOTE: 90284 will be approved for payment based on diagnosis code that proves medical necessity.						
90375*	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.						
90376*	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.						
90385	No	No	No	No	No	No
NOTE: Procedure code 90385 is limited to one injection per pregnancy.						
90386	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No
NOTE: Indicate dose and attach manufacturer's invoice.						
90630	No	18y & up	No	No	No	No
NOTE: Covered for beneficiaries who are not pregnant						
90630	EP, TJ	18 only	No	No	No	No
NOTE: Covered for beneficiaries who are not pregnant						
90630	SL	18y & up	No	No	No	No
NOTE: Covered for beneficiaries who are not pregnant						
90632	No	19y & up	No	No	No	No
90633	EP, TJ	1y – 18y	No	No	No	No
90633	SL	0 – 18y	No	No	No	No
90634	EP, TJ	1y – 18y	No	No	No	No
90634	SL	1y – 18y	No	No	No	No
90636	EP, TJ	18y	No	No	No	No
90636	SL	18y	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90636	No	19y & up	No	No	No	No
90645	EP, TJ	0 – 18y	No	No	No	No
90645	SL	0 – 18y	No	No	No	No
90645	No	19y & up	No	No	No	No
90646	EP, TJ	0 – 18y	No	No	No	No
90646	SL	0 – 18y	No	No	No	No
90646	No	19y & up	No	No	No	No
90647	EP, TJ	0 – 18y	No	No	No	No
90647	SL	0 – 18y	No	No	No	No
90647	No	19y & up	No	No	No	No
90648	EP, TJ	0 – 18y	No	No	No	No
90648	SL	0 – 18y	No	No	No	No
90649	EP, TJ	9y – 18y	No	No	No	No
90649	SL	9y – 18y	No	No	No	No
90650	EP, TJ	9y – 18y	No	No	No	No
90650	SL	9y – 18y	No	No	No	No
90651	No	9y – 18y	No	No	No	No
90651	SL	9y – 18y	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90651	EP, TJ	9y – 18y	No	No	No	No
90654	EP, TJ	18y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90654	SL	18y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90654	No	19y – 64y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90655	EP, TJ	6m – 35m	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90655	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90656	EP, TJ	3y – 18y	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90656	SL	3y – 18y	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90656	No	19y & up	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90657	EP, TJ	6m – 35m	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: See Subsections A through E of this section for additional instructions.						
90657	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90657	No	19y & up	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90658	EP, TJ	3y – 18y	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90658	SL	3y – 18y	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90658	No	19y & up	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90660	EP, TJ	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90660	SL	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90660	No	19y – 49y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90662	No	65y & up	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90669	EP, TJ	0 – 5y	No	No	No	No
90669	SL	0 – 5y	No	No	No	No
90670	EP, TJ	0 – 5y	No	No	No	No
90670	SL	0 – 5y	No	No	No	No
90672	EP, TJ	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90672	SL	2y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90672	No	19y – 49y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90673	EP, TJ	18y	No	No	No	No
90673	SL	18y	No	No	No	No
90673	No	19y – 49y	No	No	No	No
90675*	No	No	No	No	No	No
NOTE: Procedure code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D 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.						
90676*	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D 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.						
90680	EP, TJ	6w – 32w	No	No	No	No
90680	SL	6w – 32w	No	No	No	No
90681	EP, TJ	6w – 32w	No	No	No	No
90681	SL	6w – 32w	No	No	No	No
90685	EP, TJ	6m – 35m	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90685	SL	6m – 35m	No	No	No	No
NOTE: See Subsections A through E of this section for additional instructions.						
90686	EP, TJ	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90686	SL	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90686	No	19y – 99y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90688	EP, TJ	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90688	SL	3y – 18y	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90688	No	19y & up	No	No	No	No
NOTE: This procedure is billable for healthy individuals who are not pregnant. See Subsections A through E of this section for additional instructions.						
90690	No	6y & up	No	No	No	No
90691	No	3y & up	No	No	No	No
90692	No	No	No	No	No	No
90696	EP, TJ	4y – 6y	No	No	No	No
90696	SL	4y – 6y	No	No	No	No
90698	EP, TJ	0 – 4y	No	No	No	No
90698	SL	0 – 4y	No	No	No	No
90700	EP, TJ	0 – 6y	No	No	No	No
90700	SL	0 – 6y	No	No	No	No
90702	EP, TJ	0 – 6y	No	No	No	No
90702	SL	0 – 6y	No	No	No	No
90703	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No
90705	No	9m & up	No	No	No	No
90706	No	1y & up	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90707	U1	21y – 44y	No	No	No	No
NOTE: Procedure code 90707 is 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.						
90707	EP, TJ	0 – 18y	No	No	No	No
90707	SL	0 – 18y	No	No	No	No
90707	No	19y – 20y	No	No	No	No
90708	No	0 – 99y	No	No	No	No
90710	EP, TJ	0 – 18y	No	No	No	No
90710	SL	0 – 18y	No	No	No	No
90710	No	0 – 20y	No	No	No	No
90712	No	0 – 20y	No	No	No	No
90713	EP, TJ	0 – 18y	No	No	No	No
90713	SL	0 – 18y	No	No	No	No
90713	No	19y & up	No	No	No	No
90714	EP, TJ	7y – 18y	No	No	No	No
90714	SL	7y – 18y	No	No	No	No
90714	No	19y & up	No	No	No	No
90715	EP, TJ	7y – 18y	No	No	No	No
90715	SL	7y – 18y	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
90715	No	19y & up	No	No	No	No
90716	EP, TJ	0 – 18y	No	No	No	No
90716	SL	0 – 18y	No	No	No	No
90716	No	0 – 20y	No	No	No	No
90717*	No	No	No	No	No	No
NOTE: Submit invoice with claim.						
90719	No	No	No	No	No	No
90720	EP, TJ	0 – 18y	No	No	No	No
90720	SL	0 – 18y	No	No	No	No
90720	No	0 – 20y	No	No	No	No
90721	EP, TJ	0 – 18y	No	No	No	No
90721	SL	0 – 18y	No	No	No	No
90721	No	1y – 20y	No	No	No	No
90723	EP, TJ	0 – 18y	No	No	No	No
90723	SL	0 – 18y	No	No	No	No
90725*	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.						
90727*	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.						
90732	EP, TJ	2y – 18y	No	No	No	No
90732	SL	2y – 18y	No	No	No	No
90732	No	2y & up	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: 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	No	No	No	No	No	No
90734	EP, TJ	0 – 18y	No	No	No	No
90734	SL	0 – 18y	No	No	No	No
90734	No	19y & up	No	No	No	No
90735	No	0 – 20y	No	No	No	No
90736	No	60y & up	No	No	No	No
NOTE: Zoster vaccine is benefit limited to once in a lifetime.						
90740	No	No	No	No	No	No
90743	EP, TJ	0 – 18y	No	No	No	No
90743	SL	0 – 18y	No	No	No	No
90744	EP, TJ	0 – 18y	No	No	No	No
90744	SL	0 – 18y	No	No	No	No
90746	No	19y & up	No	No	No	No
90747	EP, TJ	0 – 18y	No	No	No	No
90747	SL	0 – 18y	No	No	No	No
90747	No	19y & up	No	No	No	No
90748	EP, TJ	0 – 18y	No	No	No	No
90748	SL	0 – 18y	No	No	No	No
90748	No	19y & up	No	No	No	No
90749*	No	No	No	No	No	No

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**. **This link is only active on page 143 of this document.**)
Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA
NOTE: Claim forms for procedure code 90749 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.						
96379*	No	No	No	No	No	No
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.						

TOC not required

212.000 Scope

~~10~~-1-~~08~~221

A. The Arkansas Medicaid Program covers podiatrist services through 42 Code of Federal Regulations, Section 440.60.

B. Arkansas Medicaid covers podiatrist services for eligible Medicaid beneficiaries of all ages.

C. Podiatrist services require a primary care physician (PCP) referral.

D. Podiatrist services include, but are not limited to, office and outpatient services, home visits, office and inpatient consultations, laboratory and X-ray services, physical therapy and surgical services. **Section 242.100** contains the full list of procedure codes applicable to podiatry services.

E. Many podiatrist services covered by the Arkansas Medicaid Program are restricted or limited.

1. Section 214.000 describes the benefit limits on the quantity of covered services clients may receive.

2. Section 220.000 describes prior-authorization requirements for certain services.

220.000 PRIOR AUTHORIZATION

There are certain surgical procedures and medical services and procedures that are not reimbursable without prior authorization, either because of federal requirements or because of the nature of the service.

DHS or its designated vendor performs prior authorizations for several medical or surgical procedures. Certain procedures are restricted to the outpatient setting unless prior authorized for inpatient services. Other services may only be billed when performed in a nursing home or skilled nursing facility setting. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

Section 242.120 contains the list of all procedure codes that require prior authorization.

242.100 Procedure Codes

~~9-1-14~~10-1-~~221~~

Sections 242.100 through 242.120 list the procedure codes payable to podiatrists. Any special billing or other requirements are described in parts A through F of this section and in Sections 242.110 and 242.120.

View or print the procedure codes for Podiatrist services.

A. Procedure codes for podiatry services provided in a nursing home or skilled nursing facility are listed in Section 242.110.

B. Procedure codes ~~**20974** and **20975**~~ for podiatry services require prior authorization. To request prior authorization, providers must contact the Arkansas Foundation for Medical Care, Inc. (AFMC) (see Section 221.000 – 221.100).

C. Procedure codes payable to podiatrists for laboratory and X-ray services are located in Section 242.130.

D. Procedure code ~~**99238**~~, Hospital Discharge Day Management, may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes ~~**99221** through **99233**~~). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

E. In addition to the CPT codes shown below, Q4101, Q4102, Q4103, Q4104, Q4105, Q4106, Q4107, Q4108, Q4121, Q4141, Q4145 and **T1015** are HCPCS codes and are payable to podiatrists. HCPCS code Q4121 requires a paper claim. HCPCS codes Q4141 and Q4145 must be billed with the manufacturer's invoice.

F. Procedure code **99353** must be billed for a service provided in a beneficiary's home.

The listed procedure codes and their descriptions are located in the *Physician's Current Procedural Terminology (CPT)* book. Section III of the Podiatrist Manual contains information on how to purchase a copy of the CPT publication.

Procedure Codes							
Q4101	Q4102	Q4103	Q4104	Q4105	Q4106	Q4107	Q4108
Q4121	Q4124	Q4141	Q4145	T1015	10060	10061	10120
10121	10140	10160	10180	11000	11042	11043	11044
11055	11056	11057	11100	11200	11201	11420	11421
11422	11423	11424	11426	11620	11621	11622	11623
11624	11626	11719	11720	11721	11730	11731	11732
11740	11750	11752	11760	11762	12001	12002	12004
12020	12021	12041	12042	12044	13102	13122	13131
13132	13133	13153	13160	14040	14041	14350	15002
15003	15004	15005	15050	15100	15101	15115	15116
15120	15121	15135	15136	15155	15156	15157	15220
15221	15240	15241	15271	15272	15273	15274	15275
15276	15277	15278	15620	15777	15999*	16000	17000
17003	17004	17110	17111	17250	17311	17312	17315
17999*	20000	20005	20200	20205	20206	20220	20225
20240	20500	20501	20520	20525	20550	20551	20552
20553	20600	20605	20612	20615	20650	20670	20680
20690	20692	20693	20694	20696	20697	20900	20910
20974**	20975**	27605	27606	27610	27612	27620	27625
27626	27648	27650	27654	27685	27687	27690	27695
27696	27698	27700	27702	27703	27704	27792	27808
27810	27814	27816	27818	27822	27823	27840	27842
27846	27848	27860	27870	27888	27889	28001	28002
28003	28005	28008	28010	28011	28020	28022	28024
28035	28043	28045	28046	28050	28052	28054	28060
28062	28070	28072	28080	28086	28088	28090	28092
28100	28102	28103	28104	28106	28107	28108	28110
28111	28112	28113	28114	28116	28118	28119	28120
28122	28124	28126	28130	28140	28150	28153	28160

28171	28173	28175	28190	28192	28193	28200	28202
28208	28210	28220	28222	28225	28226	28230	28232
28234	28238	28240	28250	28260	28261	28262	28264
28270	28272	28280	28285	28286	28288	28289	28290
28292	28293	28294	28296	28297	28298	28299	28300
28302	28304	28305	28306	28307	28308	28310	28312
28313	28315	28320	28322	28340	28341	28344	28345
28358	28360	28400	28405	28406	28415	28420	28430
28435	28436	28445	28450	28455	28456	28465	28470
28475	28476	28485	28490	28495	28496	28505	28510
28515	28525	28530	28540	28545	28546	28555	28570
28575	28576	28585	28600	28605	28606	28615	28630
28635	28645	28660	28665	28666	28675	28705	28715
28725	28730	28735	28737	28740	28750	28755	28760
28800	28805	28810	28820	28825	28890*	28899*	29345
29355	29358	29365	29405	29425	29435	29440	29445
29450	29505	29515	29520	29540	29550	29580	29750
29893	29894	29895	29897	29898	29899	29904	29905
29906	29907	29999*	36591	36592	64450	64455	64550
64632	64704	64782	73592	73600	73610	73615	73620
73630	73650	73660	82962	87070	87101	87102	87106
87184	93922	93923	93924	93925	93926	93930	93931
93965	93970	93971	95831	95851	97597	99201	99202
99203	99204	99205	99211	99212	99213	99214	99215
99221	99222	99223	99231	99232	99233	99238	99241
99242	99243	99244	99245	99251	99252	99253	99254
99255	99281	99282	99283	99284	99341	99342	99343
99347	99348	99349	99353				

*Procedure codes **15999, 17999, 28890, 28899**, and **29999** are manually priced and require an operative report attached to a paper claim.

Procedure codes **20974 and **20975** require prior authorization. See Section 221.000 for detailed instructions.

242.110 Procedure Codes Payable in a Nursing Care Facility

9-1-1410-1-221

The following procedure codes may be billed when these services are provided in a nursing care facility.

View or print the procedure codes for Podiatrist services.

Q4101	Q4102	Q4103	Q4104	Q4105	Q4106	Q4107	Q4108
Q4121	Q4124	Q4141	Q4145	10060	10061	10120	10121
10160	10180	11040	11055	11056	11057	11200	11201
11420	11421	11422	11423	11424	11426	11720	11721
11730	11731	11732	11740	11750	12001	12020	12021
12041	15002	15003	15004	15005	15271	15272	15273
15274	15275	15276	15277	15278	15777	16000	20550
20551	20552	20553	20612	28190	28630	28660	64455
82962	87070	87102	99241	99242	99243	99244	99245
99304	99305	99306	99307	99308	99309	99310	99318

242.120 Procedure Codes Requiring Prior Authorization

5-1-0810-1-221

The following procedure codes require prior authorization before services may be provided.

View or print the procedure codes for Podiatrist services.

20974	20975

242.130 Procedure Codes Payable for Laboratory and X-Ray Services

8-1-0410-1-221

The following procedure codes may be billed for laboratory and X-ray services. Section 214.300 contains information regarding the $500.00 benefit limit for laboratory and X-ray services established for individuals age 21 and over.

View or print the procedure codes for Podiatrist services.

73592	73600	73610	73615	73620	73630	73650
73660	82962	87070	87101	87102	87106	87184

242.310 Completion of CMS-1500 Claim Form

12-15-1410-1-221

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.

Field Name and Number		Instructions for Completion
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.

Field Name and Number	Instructions for Completion
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Podiatrist Services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections **242.100** through 242.130.
MODIFIER	Not applicable to Podiatrist Services claims.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

242.100 CPT Procedure Codes

10-13-03-221

The following CPT procedure codes are applicable to portable X-ray services:

Chest films not involving the use of contrast media:

71010	71015	71020	71021	71022
71030	71035	71100	71101	71110
71111	71120	71130		

Abdominal films not involving the use of contrast media:

74000	74010	74020	74022

Skeletal films involving arms and legs, pelvis, vertebral column and skull:

70100	70110	70120	70130	70134
70140	70150	70160	70200	70210
70220	70240	70250	70260	70328
70330	72010	72020	72040	72050
72052	72069	72070	72072	72074
72080	72090	72100	72110	72114
72120	72170	72190	72200	72202
72220	73000	73010	73020	73030
73050	73060	73070	73080	73090
73092	73100	73110	73120	73130
73140	73500	73510	73520	73540
73550	73560	73562	73564	73565
73590	73592	73600	73610	73620
73630	73650	73660		

View or print the procedure codes for Portable X-ray services.

242.110 Transportation of Portable X-Ray Services

10-13-03-221

Procedure Code	Description
R0070	Transportation of portable X-ray equipment and personnel to home or nursing home, per trip to facility or location, one patient seen, with the Medicaid maximum per trip.

View or print the procedure codes for Portable X-ray services.

Procedure code ~~R0070~~ represents the mileage and setup. If more than one Medicaid patient is seen at a place of service, the Medicaid maximum must be divided by the number of Medicaid patients seen.

242.310 Completion of CMS-1500 Claim Form

~~9-1-14~~10-1-~~22~~4

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.

Field Name and Number		Instructions for Completion
a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b.	RESERVED	Reserved for NUCC use.
	SEX	Not required.
c.	RESERVED	Reserved for NUCC use.
d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a.	INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
b.	OTHER CLAIM ID NUMBER	Not required.
c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation. 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable to portable X-ray.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections **242.100** through **242.110**.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

212.203 Cochlear Implants for Beneficiaries Under Age 21 ~~8~~10-1-2~~2~~1

Cochlear implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of 21 years through the Child Health Services (EPSDT) program when prescribed by a physician.

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components, or a switch from a body-worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware are not considered medically necessary and will not be approved.

A. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processors will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

B. Personal FM (Frequency Modulation) Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available from any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A request for prior authorization may be submitted for medically necessary FM systems (procedure code ~~V5273~~ for use with cochlear implant) that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

C. Replacement, Repair, Supplies

The repair or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics Programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

D. Prior Authorization

A request for prior authorization of a medically necessary FM system (~~V5273~~ for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to the Arkansas Foundation for Medical Care (AFMC) using form **DMS-679A**. All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization.
View or print form DMS-679A and instructions for completion.

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for, and payment of, services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

The table below contains new and existing HCPCS procedure codes for FM systems for use with cochlear implant and replacement cochlear implant parts.

NOTE: Coverage and billing requirements for the physician provider for cochlear device implantation are unchanged.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~Procedure Code~~	~~M1~~	~~Age Restriction~~	~~PA~~	~~Payment Method~~
~~L8627*~~	~~EP~~	~~0-20~~	~~Y~~	~~Manually Priced~~
~~L8628*~~	~~EP~~	~~0-20~~	~~Y~~	~~Manually Priced~~
~~L8629*~~	~~EP~~	~~0-20~~	~~Y~~	~~Manually Priced~~

*Denotes paper claim

See Section 242.155 for information on billing and reimbursement for FM system and replacement cochlear implant parts.

212.210 DME Low-Profile Percutaneous Cecostomy Tube (Low-Profile Button) for Beneficiaries of All Ages

~~12-1-2010-~~ 1-221

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes. **(View ICD codes.)**

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~44300~~	~~49442~~	~~49450~~

232.000 Specialized Wheelchair, Seating and Rehabilitative Equipment Reimbursement for Repairs

~~8-1-0510-1-~~ 242

Reimbursement for **repairs** of specialized wheelchairs will be the manufacturer's list price for parts listed less 40% manual equipment (dealer discount), 30% power equipment (dealer discount), plus 35% (profit margin), plus labor billed by the unit (15 min. = 1 unit). A maximum of twenty (20) units (20 units = 5 hours of labor) per date of service is allowable. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to the claim form.

Reimbursement for specialized wheelchair equipment, seating and rehab items requiring manual pricing is calculated using the manufacturer's current published suggested retail price less 15%. Any applicable pages from the manufacturer's catalog that reflect a description and the manufacturer's current published suggested retail price must be attached to the claim.

Kaye Products will be reimbursed at a set rate; therefore, the Kaye Products (procedure codes ~~E1031~~, modifiers **EP**, **U1**; ~~E1031~~, modifiers **EP**, **U3**; and ~~E1031~~, modifiers **EP**, **U4**) may be billed electronically.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

233.000 Orthotic and Prosthetic Reimbursement for Repairs

~~11-1-17~~10-1-~~22~~4

Providers must bill for the repair of orthotic appliances and prosthetic devices utilizing the procedure codes listed in the table below. One unit of service equals 15 minutes. A maximum of 20 units of service is allowed per date of service. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to all repair claims.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~National Procedure Code~~	~~Required Modifier~~	~~Description~~
~~L4205~~	~~—~~	~~Repair of orthotic appliances and prosthetic devices (non-EPSDT)~~
~~L4210~~	~~—~~	
~~L7510~~	~~—~~	
~~L7520~~	~~—~~	
~~L4205~~	~~EP~~	~~Repair of orthotic appliances and prosthetic devices (EPSDT)~~
~~L4210~~	~~EP~~	
~~L7510~~	~~EP, UB~~	
~~L7520~~	~~—~~	

Reimbursement for orthotic appliances and prosthetic devices requiring **manual pricing** will be calculated using the manufacturer's invoice price plus 10%. The manufacturer invoice must be attached to all repair claims.

236.000 Reimbursement for Repair of the Enteral Nutrition Pump

~~8-1-21~~10-1-~~22~~4

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request**.

Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* (**View or print form DMS-679A and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code ~~**B9000** or **B9002**~~ after receiving prior authorization for the new piece of equipment.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.110 Respiratory and Diabetic Equipment, All Ages

~~11-1-17~~10-1-22~~1~~

When billed either electronically or on paper, procedure codes found in this section must be billed with certain modifiers. Modifiers in the section are indicated by the headings M1 and M2. When only the **NU** modifier is shown in the M1 column, the procedure code may be billed for beneficiaries of all ages. When **NU** and **EP** are listed together in the M1 column, the NU modifier must be used when billing for beneficiaries age 21 and over, and the EP modifier must be used when billing for beneficiaries under age 21. When a modifier is listed in the M2 heading, that modifier must be used in conjunction with either **NU** or **EP**.

Prior authorization requirements are shown under the heading PA. If prior authorization is needed, the information is indicated with a "Y" in the column; if not, an "N" is shown.

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

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~**Respiratory and Diabetic Equipment, All Ages (Section 242.110)**~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~
~~A4230~~	~~NU~~		~~Infusion set for external insulin pump, non-needle cannula type~~	~~Y♦~~	~~Purchase~~
~~A4231~~	~~NU~~		~~Infusion set for external insulin pump, needle type~~	~~Y♦~~	~~Purchase~~
~~A4232~~	~~NU~~		~~Syringe with needle for external insulin pump, sterile, 3 cc~~	~~Y♦~~	~~Purchase~~
~~A4627~~	~~NU~~	~~UB~~	~~⁂(Spacer bag or reservoir without mask, for use with metered dose inhaler) Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler~~	~~N~~	~~Purchase~~

Respiratory and Diabetic Equipment, All Ages (Section 242.110)

National Procedure Code	M1	M2	Description	PA	Payment Method
A4627	NU		**(Spacer bag or reservoir with mask, for use with metered dose inhaler) Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler	N	Purchase
A7045	NU		Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	N	Purchase
A7046	NU		Water chamber for humidifier, used with positive airway pressure device, replacement, each	N	Purchase
E0424	NU		Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Y♦	Rental Only
E0430	NU		Portable gaseous oxygen system, purchase, includes regulator, flowmeter, humidifier, cannula or mask, and tubing	Y♦	Rental Only
E0434	NU		Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing	Y♦	Rental Only
E0435	NU		Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adapter	Y♦	Rental Only
E0439	NU		Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Y♦	Rental Only
E0441	NU		Oxygen contents, gaseous (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned), one month's supply = l unit	Y	Purchase
E0442	NU		Oxygen contents, liquid (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned), one month's supply = 1 unit	Y	Purchase
E0443	NU		Portable oxygen contents, gaseous (for use only with portable gaseous systems when no stationary gas or liquid system is used), one month's supply=1 unit	Y♦	Purchase

Respiratory and Diabetic Equipment, All Ages (Section 242.110)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0444	NU		Portable oxygen contents, liquid (for use only with portable liquid systems when no stationary gas or liquid system is used), one month's supply=1 unit	Y♦	Purchase
E0470	NU EP	RR RR	⁂(BIPAP Device, Nasal Bi-level Positive Airway support system; includes necessary accessory items. **NOTE: Complete medical data pertinent to the request must be submitted with the prior authorization request.**) Respiratory assist device, bi-level pressure capacity, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Y♦ Y♦	Rental Only
E0471	NU EP	RR RR	Respiratory assist device, bi-level pressure capacity, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Y♦ Y♦	Rental Only
E0472	NU EP	RR RR	Respiratory assist device, bi-level pressure capacity, with backup rate feature, used with invasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)	Y♦ Y♦	Rental Only
E0482	NU EP		Cough stimulating device, alternating positive and negative airway pressure	Y♦	Capped Rental
E0483	NU	RR	⁂(Bronchial Drainage System) High-frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each	Y♦	Capped Rental
E0483	NU	UB	⁂(Pulmonary Vest. **The manufacturer invoice must be attached to the claim form.**) High-frequency chest wall oscillation air-pulse generator system (includes hoses and vest), each	Y♦	Purchase
E0560	NU UE		Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery	N	Purchase
E0561	NU EP		Humidifier, non-heated, used w/positive airway pressure device	Y♦ Y♦	Purchase
E0562	NU EP		Humidifier, heated, used w/positive airway pressure device	Y♦ Y♦	Purchase
E0570	NU UE		Nebulizer, with compressor	Y♦	Purchase

~~Respiratory and Diabetic Equipment, All Ages (Section 242.110)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~
~~E0575~~	~~NU UE~~		~~Nebulizer, ultrasonic, large volume~~	~~Y♦~~	~~Capped Rental~~
~~E0600~~	~~NU UE~~		~~Respiratory suction pump, home model, portable or stationary, electric~~	~~N~~	~~Rental Only~~
~~E0601~~	~~NU~~	~~RR~~	~~⁂(CPAP Device Nasal Continuous Positive Airway Pressure (CPAP) Device; includes necessary accessory items)~~ ~~**NOTE: Complete medical data pertinent to the request must be submitted with the prior authorization request. NOTE: Bill E0601 as the global daily rental service.**~~	~~Y♦~~	~~Rental Only~~
~~E0784~~	~~NU~~		~~External ambulatory infusion pump, insulin~~	~~Y♦~~	~~Purchase~~
~~E1354~~	~~NU~~		~~Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each~~	~~Y~~	~~Manually priced~~
~~E1390~~	~~NU~~		~~Oxygen concentrator, single delivery port, capable of delivering 85 % or greater oxygen concentration at the prescribed flow rate~~	~~Y♦~~	~~Rental Only~~
~~E1391~~	~~NU~~		~~O2 concentrator, dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, each~~	~~Y♦~~	~~Rental Only~~

242.111 Initial Rental of a DME Item for Individuals of All Ages

~~11-1-17~~10-1-22

Procedure codes found in this section may be billed either electronically or on paper.

Some procedure codes have been assigned a modifier that affects the billing process. Required modifiers are indicated in the M1 column in the list below. When a modifier is shown in the M1 column, it must be listed along with the procedure code when requesting payment by Arkansas Medicaid.

Procedure codes shown in the list below are either covered for all ages (AA), only for individuals under age 21 (U21) or only for individuals age 21 and over (21+). A column in the list below defines the differences.

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

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Initial Rental of a DME Item for Individuals of All Ages (Section 242.111)

National Procedure Code	M1	Description	All U21 21+
E0181		Pressure pad, alternating with pump, heavy duty	U21
E0200		Heat lamp, without stand (table model), includes bulb, or infrared element	U21
E0205		Heat lamp, with stand includes bulb, or infrared element	U21
E0217		Water circulating heat pad with pump	U21
E0225		Hydrocollator unit, includes pad	U21
E0236		Pump for water circulating pad	U21
E0239		Hydrocollator unit, portable	U21
E0250♦		Hospital bed, fixed height, with any type side rails, with mattress	U21
E0250♦	U1	Hospital bed, fixed height, with any type side rails, with mattress	U21
E0250♦	UE	Hospital bed, fixed height, with any type side rails, with mattress	21+
E0255♦		Hospital bed, variable height; hi-lo, with any type side rails, with mattress	U21
E0255	KH	Hospital bed, variable height; hi-lo, with any type side rails, with mattress	21+
E0260♦		Hospital bed, semi-electric (head and foot adjustment), with any type side rails with mattress	U21
E0260♦	KH	Hospital bed, semi-electric (head and foot adjustment), with any type side rails with mattress	21+
E0271		Mattress, inner spring	U21
E0272		Mattress, foam rubber	U21
E0303		Hospital bed, heavy-duty, extra wide, with weight capacity > 350 but < or = 600, any type side rails, w/mattress	AA
E0424		Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator flowmeter, humidifier, nebulizer cannula or mask, and tubing	AA
E0430♦		Portable gaseous oxygen system, purchase, includes regulator, flowmeter, humidifier, cannula, or mask, and tubing	AA
E0434		Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing	AA
E0435♦		Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adapter	AA

Initial Rental of a DME Item for Individuals of All Ages (Section 242.111)

National Procedure Code	M1	Description	All U21 21+
E0439		Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	AA
E0445♦		Oximeter for measuring blood oxygen levels non-invasively. ⁂ (Pulse oximeter, including 4 disposable probes)	AA
E0480		Percussor, electric or pneumatic, home model	U21
E0565♦		Compressor, air power source for equipment which is not self-contained or cylinder driven	U21
E0575♦		Nebulizer, ultrasonic, large volume	AA
E0585		Nebulizer, with compressor and heater	U21
E0600		Respiratory suction pump, home model, portable or stationary, electric	AA
E0606		Vaporizer, room type	U21
E0630♦		Patient lift, hydraulic, with seat or sling	U21
E0630	KH	Patient lift, hydraulic, with seat or sling	21+
E0650♦		Pneumatic compressor, nonsegmental home model	U21
E0667♦		Segmental pneumatic appliance for use with pneumatic compressor, full leg	U21
E0668♦		Segmental pneumatic appliance for use with pneumatic compressor, full arm	U21
E0691		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less	U21
E0692		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; four foot panel	U21
E0693		Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; six foot panel	U21
E0694		Ultraviolet multidirectional light therapy system in six foot cabinet includes bulbs/lamps, timer and eye protection	U21
E0720♦		TENS, two lead, localized stimulation	U21
E0730♦		Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	AA
E0730♦	KH	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	21+
E0745♦		Neuromuscular stimulator, electronic shock unit	U21
E0779♦		⁂(Ambulatory infusion device, payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home) Ambulatory infusion device pump, mechanical, reusable, for infusion 8 hours or greater	AA

Initial Rental of a DME Item for Individuals of All Ages (Section 242.111)

National Procedure Code	M1	Description	All U21 21+
E0910		Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	AA
E0910	KH	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	21+
E0911		Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	AA
E0920		Fracture frame, attached to bed, includes weights	U21
E0930		Fracture frame, freestanding, includes weights	U21
E0935♦		Passive motion exercise device	U21
E0940		Trapeze bar, freestanding, complete with grab bar	U21
E0941		Gravity assisted traction device, any type	U21
E1130♦		Standard wheelchair, fixed full-length arms, fixed or swing-away, detachable footrests	U21
E1130♦	KH	Standard wheelchair, fixed full-length arms, fixed or swing-away, detachable footrests	21+
E1224♦		Wheelchair with detachable arms, elevating legrests	AA
E1224♦	U1	⁂(Footrests wheelchair with detachable arms, elevating leg rests) Wheelchair with detachable arms, elevating legrests	21+
E1390		Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate	AA
E1391		Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each	AA

Providers will be reimbursed for a minimum of 30 days of rental when the equipment is used less than 30 days. Initial rental codes must be billed when equipment is used less than 30 days during the first month of rental.

Arkansas Medicaid will only reimburse for one initial minimum 30 days of rental per state fiscal year period per beneficiary per procedure code. The provider will not be reimbursed for the same procedure code utilizing another modifier for the same time period.

242.112 Home Blood Glucose Monitor and Supplies – Pregnant Women Only, All Ages

~~11-1-17~~10-1-22~~1~~

Procedure codes found in this section must be billed either electronically or on paper with modifier **NU** for individuals of all ages. When a second modifier is listed, that modifier must be used in conjunction with the **NU** modifier.

Modifiers in the section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

National Procedure Code	M1	M2	Description	PA	Payment Method
E0607	NU	U1	Home Blood Glucose Monitor	N	Purchase
A4253	NU	U1	Blood glucose test or reagent strips for home glucose monitor, per 50 strips	N	Purchase
A4259	NU	U2	Lancets, per box of 100	N	Purchase

242.120 Medical Supplies for Beneficiaries of All Ages

8-15-18 10-1-22

Procedure codes found in this section must be billed either electronically or on paper using modifier **NU** for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the modifier **NU**.

Modifiers in this section are indicated by the headings M1 and M2

[1] Not all medical supplies require prior authorization. Supplies with this symbol require prior authorization. Form DMS-679A must be used to request prior authorization. Note: Compression burn garments are manually priced. The manufacturer's invoice must be submitted with the request for compression burn garments. View or print form DMS-679A and instructions for completion.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A4206	NU		Syringe with needle, sterile, 1 cc., each
A4207	NU		Syringe with needle, sterile, 2 cc., each
A4209	NU		Syringe with needle, sterile, 5 cc. or greater, each
A4213	NU		Syringe, sterile, 20 cc. or greater, each
A4216	NU		Sterile water/saline and/or dextrose, diluent/flush, 10 ml.
A4217	NU		Sterile water/saline, 500 ml.
A4221[1]	NU		Supplies for maintenance of drug infusion catheter, per week (list drug separately)
A4222[1]	NU		Supplies for external drug infusion pump, per cassette or bag (list drug separately)

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A4224	NU		Supplies for maintenance of insulin infusion catheter, per week
A4225	NU		Supplies for external insulin infusion pump, syringe type cartridge, sterile, each
A4253	NU	UB	**(Blood glucose test or reagent strips for home blood glucose monitor, per 25 strips)
A4253	NU		Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4256	NU		Normal, low, and high calibrator solution/chips
A4259	NU		Lancets, per box of 100
A4265	NU		Paraffin, per lb.
A4310	NU		Insertion tray without drainage bag and without catheter (accessories only)
A4311	NU		Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4312	NU		Insertion tray without drainage bag with indwelling catheter, Foley type, 2-way, all silicone
A4313	NU		Insertion tray without drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation
A4314	NU		Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4315	NU		Insertion tray with drainage bag with indwelling catheter, Foley type, 2-way, all silicone
A4316	NU		Insertion tray with drainage bag with indwelling catheter, Foley type, 3-way, for continuous irrigation
A4320	NU		Irrigation tray with bulb or piston syringe, any purpose
A4322	NU		Irrigation syringe, bulb or piston, each
A4326	NU		Male external catheter, with integral collection chamber, any type each
A4327	NU		Female external urinary collection device; metal cup, each
A4328	NU		Female external urinary collection device; pouch, each
A4330	NU		Perianal fecal collection pouch with adhesive, each
A4331	NU		Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each
A4338	NU		Indwelling catheter, Foley type, 2-way latex with coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4340	NU		Indwelling catheter; specialty type (e.g., Coude, mushroom, wing, etc.), each

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A4344	NU		Indwelling catheter, Foley type, 2-way, all silicone, each
A4346	NU		Indwelling catheter, Foley type, 3-way for continuous irrigation, each
A4349	NU		Male external catheter with or without adhesive, disposable, each
A4351	NU		Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4351	NU	U1	Intermittent urinary catheter; disposable straight tip, with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4352	NU		Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric or hydrophilic, etc.), each
A4352	NU	U1	Intermittent urinary catheter; Coude (curved) tip, with or without coating (Teflon, silicone, silicone elastomeric or hydrophilic, etc.), each
A4353	NU		Intermittent urinary catheter, with insertion supplies
A4353	NU	U2	Intermittent urinary catheter, with insertion supplies
A4354	NU		Insertion tray with drainage bag but without catheter
A4355	NU		Irrigation tubing set for continuous bladder irrigation through a 3-way indwelling Foley catheter, each
A4356	NU		External urethral clamp or compression device (not to be used for catheter clamp), each
A4357	NU		Bedside drainage bag, day or night, with or without anti reflux device, with or without tube, each
A4358	NU		Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each
A4361	NU		Ostomy faceplate, each
A4362	NU		Skin barrier; solid, four by four or equivalent; each
A4364	NU		Adhesive, liquid, or equal, any type, per oz.
A4367	NU		Ostomy belt, each
A4368	NU		Ostomy filter, any type, each
A4369	NU		Ostomy skin barrier, liquid, (spray, brush, etc.), per oz.
A4371	NU		Ostomy skin barrier, powder, per oz.
A4394	NU		Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fl. oz.
A4397	NU		Irrigation supply; sleeve, each
A4398	NU		Ostomy irrigation supply; bag, each
A4399	NU		Ostomy irrigation supply; cone/catheter, including brush
A4400	NU		Ostomy irrigation set

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A4402	NU		Lubricant, per oz.
A4404	NU		Ostomy ring, each
A4405	NU		Ostomy skin barrier, nonpectin-based, paste, per oz.
A4406	NU		Ostomy skin barrier, pectin-based, paste, per oz.
A4407	NU		Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 in. or smaller, each
A4414	NU		Ostomy skin barrier, with flange (solid, flexible or accordion), without built-in convexity, 4 x 4 in. or smaller, each
A4425	NU		Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each
A4435	NU		Ostomy pouch, drainable, high output, with extended wear barrier (one piece system), with or without filter, each
A4450	NU	U1	Tape, nonwaterproof, per 18 sq. in.
A4452	NU		Tape, waterproof, per 18 sq. in.
A4455	NU		Adhesive remover or solvent (for tape, cement or other adhesive), per oz.
A4456	NU		Adhesive remover; any type
A4483	NU	U1	**(non-vent, trach nose) Moisture exchanger, disposable, for use with invasive mechanical ventilation
A4558	NU		Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz.
A4561	NU	U1	Pessary, rubber, any type
A4562	NU		Pessary, non-rubber, any type
A4623	NU		Tracheostomy, inner cannula
A4624	NU		Tracheal suction catheter, any type other than closed system, each
A4625	NU		Tracheostomy care kit for new tracheostomy
A4626	NU		Tracheostomy cleaning brush, each
A4628	NU		Oropharyngeal suction catheter, each
A4629	NU		Tracheostomy care kit for established tracheostomy
A4772	NU		Blood glucose test strips, for dialysis, per 50
A4927	NU		Gloves, non-sterile, per 100
A5051	NU		Ostomy pouch, closed; with barrier attached (1 piece), each
A5052	NU		Ostomy pouch, closed; without barrier attached (1 piece), each
A5053	NU		Ostomy pouch, closed; for use on faceplate, each
A5054	NU		Ostomy pouch, closed; for use on barrier with flange (2 piece), each
A5055	NU		Stoma cap

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National Procedure Code	M1	M2	Description
A5056	NU		Ostomy pouch, drainable; with extended wear barrier attached, with filter, 1 piece, each
A5057	NU		Ostomy pouch, drainable; with extended wear barrier attached, with built in convexity, with filter, 1 piece, each
A5061	NU	U1	Ostomy pouch, drainable; with barrier attached (1 piece), each
A5062	NU		Ostomy pouch, drainable; without barrier attached (1 piece), each
A5063	NU		Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each
A5071	NU		Ostomy pouch, urinary; with barrier attached (1 piece), each
A5072	NU		Ostomy pouch, urinary; without barrier attached (1 piece), each
A5073	NU		Ostomy pouch, urinary; for use on barrier with flange (2 piece), each
A5081	NU		Continent device; plug for continent stoma
A5082	NU		Continent device; catheter for continent stoma
A5093	NU		Ostomy accessory; convex insert
A5102	NU		Bedside drainage bottle, with or without tubing, rigid or expandable, each
A5105	NU		Urinary suspensory with leg bag, with or without tube, each
A5112	NU		Urinary leg bag; latex
A5113	NU		Leg strap; latex, replacement only, per set
A5114	NU		Leg strap; foam or fabric, replacement only, per set
A5120	NU		Skin barrier, wipes or swabs, each
A5121	NU		Skin barrier; solid, 6 x 6 or equivalent, each
A5122	NU		Skin barrier; solid, 8 x 8 or equivalent, each
A5126	NU		Adhesive or non-adhesive; disk or foam pad
A5131	NU		Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A6021	NU		Collagen dressing, sterile, size 16 sq. in. or less, each
A6022	NU		Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each
A6023	NU		Collagen dressing, sterile, size more than 48 sq. in., each
A6024	NU		Collagen dressing wound filler, sterile, per 6 in.
A6154	NU		Wound pouch, each
A6196	NU		Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing
A6197	NU		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A6197	NU	UB	Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each dressing ⁂(1 linear yard)
A6198	NU		Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing
A6203	NU		Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6204	NU		Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6205	NU		Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6209	NU		Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing
A6210	NU		Foam dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6211	NU		Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6212	NU		Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6213	NU		Foam dressing, wound cover, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6216	NU		Gauze, nonimpregnated, non sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6219	NU		Gauze, nonimpregnated, sterile, 16 sq. in. or less with any size adhesive border, each dressing
A6220	NU		Gauze, non-impregnated, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6221	NU		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6228	NU		Gauze, impregnated, water or normal saline, sterile, pad, size 16 sq. in. or less, without adhesive border, each dressing
A6229	NU		Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6230	NU		Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6234	NU		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A6234	NU	U1	**(Hydrocolloid dressing, wound cover, sterile, pad size greater than 16 sq. in. , without adhesive border, each dressing)
A6235	NU		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6236	NU		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6237	NU		Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6237	NU	U1	**(Hydrocolloid dressing, wound cover, sterile, pad size greater than 16 sq. in., with any size adhesive border, each dressing)
A6238	NU		Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6238	NU	U1	Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6239	NU		Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing
A6241	NU		Hydrocolloid dressing, wound filler, dry form, sterile, per gram
A6242	NU		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing
A6242	NU	U1	**(Hydrogel dressing, wound cover, sterile, pad size greater than 16 sq. in., without adhesive border, each dressing)
A6243	NU		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing
A6244	NU		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in. without adhesive border, each dressing
A6245	NU		Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing
A6246	NU		Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing
A6247	NU		Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in. with any size adhesive border, each dressing
A6248	NU		Hydrogel dressing, wound filler, gel, sterile, per fl. oz.
A6248	NU	U1	Hydrogel dressing, wound filler, gel, sterile, per fl. oz.
A6257	NU		Transparent film, sterile, 16 sq. in. or less, each dressing
A6258	NU		Transparent film, sterile, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A6259	NU		Transparent film, sterile, more than 48 sq. in., each dressing
A6403	NU		Gauze, nonimpregnated, sterile, pad size more than 16 sq. in. less than 48 sq. in., without adhesive border, each dressing
A6404	NU		Gauze, nonimpregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing
A6441	NU		Padding bandage, nonelastic, nonwoven/nonknitted, width greater than or equal to 3 in. and less than 5 in., per yd.
A6442	NU		Conforming bandage, nonelastic, knitted/woven, nonsterile, width less than 3 in., per yd.
A6443	NU		Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 3 in. and less than 5 in., per yd.
A6444	NU		Conforming bandage, nonelastic, knitted/woven, nonsterile, width greater than or equal to 5 in., per yd.
A6445	NU		Conforming bandage, nonelastic, knitted/woven sterile, width less than 3 in., per yd.
A6446	NU		Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 3 in. and less than 5 in., per yd.
A6447	NU		Conforming bandage, nonelastic, knitted/woven, sterile, width greater than or equal to 5 in., per yd.
A6448	NU		Light compression bandage, elastic, knitted/woven width less than 3in., per yd.
A6449	NU		Light compression bandage, elastic, knitted/woven, width greater than or equal to 3 in. and less than 5 in., per yd.
A6450	NU		Light compression bandage, elastic, knitted/woven, width greater than or equal to 5 in., per yd.
A6451	NU		Moderate compress bandage, elastic, knitted/woven load resistance of 1.25 to 1.34 ft. lbs. at 50% maximum stretch, width greater than or equal to 3 in. and less than 5 in., per yd.
A6452	NU		High compress bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 ft. lbs. at 50 % maximum stretch, width greater than or equal to 3 in. and less than 5 in., per yd.
A6453	NU		Self-adherent bandage, elastic, nonknitted/nonwoven, width less than 3 in., per yd.
A6454	NU		Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 3 in and less than 5 in., per yd.
A6455	NU		Self-adherent bandage, elastic, nonknitted/nonwoven, width greater than or equal to 5 in., per yd.
A6501[1]	NU		Compression burn garment, bodysuit (head to foot), custom fabricated
A6502[1]	NU		Compression burn garment, chin strap, custom fabricated
A6503[1]	NU		Compression burn garment, facial hood, custom fabricated

Medical Supplies, All Ages (Section 242.120)

National Procedure Code	M1	M2	Description
A6504[1]	NU		Compression burn garment, glove to wrist, custom fabricated
A6505[1]	NU		Compression burn garment, glove to elbow, custom fabricated
A6506[1]	NU		Compression burn garment, glove to axilla, custom fabricated
A6507[1]	NU		Compression burn garment, foot to knee length, custom fabricated
A6508[1]	NU		Compression burn garment, foot to thigh length, custom fabricated
A6509[1]	NU		Compression burn garment, upper trunk to waist including arm openings (vest), custom fabricated
A6510[1]	NU		Compression burn garment, trunk including arms down to leg openings (leotard), custom fabricated
A6511[1]	NU		Compression burn garment, lower trunk including leg openings (panty), custom fabricated
A6512[1]	NU		Compression burn garment, not otherwise classified
A6513[1]	NU		Compression burn mask, face and/or neck, plastic or equal, custom fabricated
A7520	NU		Tracheostomy/laryngectomy tube, noncuffed, polyvinylchloride (PVC), silicone or equal, each
A7521			Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each
A7522			Tracheostomy/laryngectomy tube, stainless steel or equal, (sterilizable and reusable), each
A7524			Tracheostoma stent/stud/button, each
A7525			Tracheostomy mask, each
B4087	NU		Gastrostomy/jejunostomy tube, standard, any material, any type, each
E0776	NU		IV pole
E0779	NU	RR	⁂(Ambulatory infusion device, payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home) Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater
J1642	NU		Injection, heparin sodium, (heparin lock flush), per 10 units

242.121 Food Thickeners, All Ages

~~11-1-17~~10-1-22~~4~~

Food thickeners, including “Thick-It,” “Thick-It II,” “Simply Thick,” “Thick and Easy” and “Thick and Clear” are not subject to the $250 medical supply benefit limit.

The modifier **NU** must be used with the procedure code found in this section and when food thickeners are to be administered enterally, the modifier “**BA**” must be used in conjunction with the procedure code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may not be rounded up. When a date span is billed, the product cannot be billed until the end date has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~
~~B4100~~	~~NU~~		~~Food thickener, administered orally, per oz.~~
~~B4100~~	~~NU~~	~~BA~~	~~Food thickener, administered enterally, per oz.~~

242.122 Jobst Stocking for Beneficiaries of All Ages ~~810~~-1-22~~1~~

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by DHS or its designated vendor. **View or print contact information for how to submit the request.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose veins with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy. **View or print form DMS-679A and instructions for completion.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~Maximum Units~~
~~A6530~~	~~NU EP~~		~~Gradient compression stocking, below knee, 18-30mm Hg, each~~	~~Maximum 4 units per date of service~~
~~A6549~~	~~NU~~		~~Gradient compression stocking, NOS (Jobst); 1 unit = 1 stocking~~	~~Maximum 4 units per date of service~~

242.123 Negative Pressure Wound Therapy Pump Accessories and Supplies for Beneficiaries Ages 2 Years and Older ~~11-1-17~~10-1-22~~1~~

Effective for dates of service on or after May 11, 2012, procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries aged 2-20 years or modifier **NU** for beneficiaries aged 21 and over.

Modifiers in this section are indicated by the heading M1. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~Negative Pressure Wound Therapy Pump Accessories and Supplies for Beneficiaries Ages 2 Years and Older (Section 242.123)~~

~~National Procedure Code~~	~~M1~~	~~Description~~	~~PA~~	~~Age Restriction~~
~~A6550~~	~~NU~~	~~Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories~~	~~Y~~	~~21 years and over~~
~~A6550~~	~~EP~~	~~Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories~~	~~Y~~	~~2-20 years~~
~~A7000~~	~~NU~~	~~Disposable canister, used with suction pump, each~~	~~Y~~	~~21 years and over~~
~~A7000~~	~~EP~~	~~Disposable canister, used with suction pump, each~~	~~Y~~	~~2-20 years~~
~~E2402~~	~~NU~~	~~Negative pressure wound therapy electrical pump, stationary or portable~~	~~Y~~	~~21 years and over~~
~~E2402~~	~~EP~~	~~Negative pressure wound therapy electrical pump, stationary or portable~~	~~Y~~	~~2-20 years~~

242.130 Diapers and Underpads for Beneficiaries Ages 3 Years and Older ~~11-1-17~~10-1-224

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~Diapers and Underpads, 3 Years Old and Older (Section 242.130)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~
~~A4335~~	~~NU~~	~~UB~~	~~Incontinence supply; miscellaneous~~	~~N~~	~~Purchase~~
~~A4554~~	~~NU~~		~~Disposable underpads, all sizes (e.g., Chux's)~~	~~N~~	~~Purchase~~
~~T4521~~	~~NU~~		~~Adult-sized disposable incontinence product, brief/diaper, small, each~~	~~N~~	~~Purchase~~

Diapers and Underpads, 3 Years Old and Older (Section 242.130)

National Procedure Code	M1	M2	Description	PA	Payment Method
T4522	NU		Adult-sized disposable incontinence product, brief/diaper, medium, each	N	Purchase
T4523	NU		Adult-sized disposable incontinence product, brief/diaper, large, each	N	Purchase
T4524	NU		Adult-sized disposable incontinence product, brief/diaper, extra large, each	N	Purchase
T4526	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, medium size, each	N	Purchase
T4527	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, large size, each	N	Purchase
T4528	NU EP		Adult-sized disposable incontinence product, protective underwear/pull-on, extra large size, each	N	Purchase
T4529	EP		⁂(Small diaper) Pediatric-sized disposable incontinence product, brief/diaper, small/medium size, each	N	Purchase
T4529	EP	U1	⁂(Medium diaper) Pediatric-sized disposable incontinence product, brief/diaper, small/medium size, each	N	Purchase
T4530	NU EP		Pediatric-sized disposable incontinence product, brief/diaper, large size, each	N	Purchase
T4531	EP		⁂(Small diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	N	Purchase
T4531	EP	U1	⁂(Medium diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	N	Purchase
T4532	NU EP		⁂(Large diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each	N	Purchase
T4532	NU EP	U1 U1	⁂(Extra large diaper) Pediatric-sized disposable incontinence product, protective underwear/pull-on, large size, each	N	Purchase
T4533	NU EP		Youth-sized disposable incontinence product, brief/diaper, each	N	Purchase

Diapers and Underpads, 3 Years Old and Older (Section 242.130)

National Procedure Code	M1	M2	Description	PA	Payment Method
T4535	NU EP		⁂(Pantyliners/Bladder Pads/Diaper Doubles) Disposable liner/shield/guard/pad/ undergarment for incontinence, each	N	Purchase
T4535	NU EP	U1 U1	⁂(Under Garment One Size Fits All) Disposable liner/shield/guard/pad/ undergarment for incontinence, each	N	Purchase
T4543	NU		Disposable incontinence product, brief/diaper, bariatric, each	N	Purchase
T4544	NU		Adult-sized disposable incontinence product, protective underwear/pull-on, above extra large each		

Reimbursement is based on a per unit basis with one unit equaling one item (diaper, underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Providers should not bill "from" and "through" dates of service.

Refer to Section 212.100 of this manual for coverage information on diapers and underpads.

242.140 Electronic Blood Pressure Monitor and Cuff, All Ages

11-1-1710-1-221

The procedure code found in this section must be billed either electronically or on paper using modifier **NU** for individuals of all ages.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

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

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

National Procedure Code	M1	M2	Description	PA	Payment Method
A4670	NU		Automatic blood pressure monitor	Y♦	Rental Only

Included with the rental of this monitor, the provider will need to supply one (1) disposable blood pressure cuff each month.

242.150 Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age

12-1-2010-1-221

The following list provides the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

The coverage listed is payable only if the service is prescribed as a result of a Child Health Services (EPSDT) screening/referral.

No prior authorization is required for nutritional formulae for EPSDT beneficiaries from age five (5) years through twenty (20) years.

Prior authorization is required for beneficiaries from birth through four (4) years. Use of modifier **U7** in the following list will be necessary, as indicated.

To request prior authorization, providers should complete the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (DMS-679A), attaching a copy of the EPSDT screening/referral as well as a prescription signed by the beneficiary's PCP. **View or print form DMS-679A**. **View or print contact information for how to submit the request.**

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC Program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preferences for formulae will not be considered for medical necessity.

Exceptions to Use of Formulae

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk or soy protein; chronic diarrhea, short gut; cystic fibrosis; fat malabsorption due to GI or liver disease.

D. Gerber Extensive HA – Allergy to milk or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome; known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen, or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24– Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. Modifier **BO** is used to bill for oral usage. When a second or third modifier is listed, that modifier must be used in conjunction with **EP**.

For beneficiaries from birth through four (4) years of age, the use of modifier **U7,** as well as additional documentation will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

Modifiers in this section are indicated by the headings M1, M2, M3 and M4.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~**Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)**~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~M3~~	~~M4~~	~~Description~~	~~Covered Formulae~~
~~B4149~~	~~EP~~				~~Enteral formula, blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit~~	
~~B4149~~	~~EP~~	~~BO~~				
~~B4149~~	~~EP~~	~~U7~~				
~~B4149~~	~~EP~~	~~U7~~	~~BO~~			
~~Ages 0 – 4 Years requires PA~~						

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4150	EP				Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4150	EP	BO				
B4150	EP	U7				
B4150	EP	U7	BO			
Ages 0 – 4 Years requires PA						
B4150	EP	U1	BO		Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4150	EP	U1	U7	BO		
Ages 0 – 4 Years requires PA						
B4152	EP				Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml), with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4152	EP	BO				
B4152	EP	U7				
B4152	EP	U7	BO			
Ages 0 – 4 Years requires PA						
B4153	EP				Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4153	EP	BO				
B4153	EP	U7				
B4153	EP	U7	BO			
Ages 0 – 4 Years requires PA						

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4154 B4154 B4154 B4154 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO		Enteral formula, nutritionally complete, for special metabolic needs, includes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4155 B4155 Bill on paper (Indicate specific name of formula on claims.)	EP EP	 BO			Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin
B4155 B4155 Ages 0 – 4 Years requires PA Bill on paper (Indicate specific name of formula on claims.)	EP EP	 U7	 BO		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP	U1 U1	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	SolCarb Scandical
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP	U2 U2	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Microlipid
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP	U3 U3	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	
B4158 B4158 B4158 B4158 Ages 0 – 4 Years requires PA	EP EP	 BO U7 U7	 BO	 	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4159 B4159 B4159 B4159 Ages 0 – 4 Years requires PA	EP EP	 BO U7 U7	 BO		Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	
B4159 B4159 B4159 B4159 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U8 U8	 U7 U7	 BO	Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, or iron, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160 B4160 B4160 B4160 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160 B4160 B4160 B4160 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U8 U8	 U7 U7	 BO	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4160	EP	U1			Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160	EP	U1	BO			
B4160	EP	U1	U7			
B4160	EP	U1	U7	BO		
Ages 0 – 4 Years requires PA						
B4160	EP	U1	U8		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4160	EP	U1	U8	BO		
Ages 0 – 4 Years requires PA						
B4161	EP				Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4161	EP	BO				
B4161	EP	U7				
B4161	EP	U7	BO			
Ages 0 – 4 Years requires PA						
B4161	EP				Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	
B4161	EP	BO				
B4161	EP	U7	U8	BO		
B4161	EP	U7	U8			
Ages 0 – 4 Years requires PA						

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4162	EP				Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Ages 0 – 4 Years requires PA
B4162	EP	BO				
B4162	EP	U7				
B4162	EP	U7	BO			
B4162	EP	U1			Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	Ages 0 – 4 Years requires PA
B4162	EP	U1	BO			
B4162	EP	U1	U7			
B4162	EP	U1	U7	BO		

One (1) unit of service equals one-hundred (100) calories with a reimbursable maximum of thirty (30) units per day. Supplies furnished by prosthetics providers in conjunction with the nutritional formula must be billed to Medicaid with the prosthetics medical supply codes. These formulae are covered as nutritional supplements rather than as the sole source of nutrition.

NOTE: Beneficiaries who require enteral nutrition as the sole source of nutrition with the formulae being administered through a nasogastric, jejunostomy or gastrostomy tube should be referred to a hyperalimentation provider enrolled in the Medicaid Program.

Each claim should reflect a "from" and "through" date of service. The claims must not be filed until after the "through" date has elapsed. Claims may be submitted on either a weekly or a monthly basis.

242.151 Pedia-Pop

~~11-1-17~~10-1-22~~4~~

The procedure code found in this section must be billed with modifier **EP**. Pedia-Pop is only for oral consumption, and is only in frozen form.

Modifiers in this section are indicated by the headings M1 and M2.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

National Procedure Code	M1	M2	Description	Maximum Units	Deleted Local Code

National Procedure Code	M1	M2	Description	Maximum Units	Deleted Local Code
B4103	EP	U1	⁂Pedia-Pop; 1 unit equals 1 box	2 units per date of service	Z2487

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit

8~~10~~-1-2~~21~~

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. When a second modifier is listed, that modifier must be used in conjunction with **EP**.

The procedure codes require prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

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

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

National Procedure Code	M1	M2	Description	Maximum Units	PA	Payment Method
B4035	EP		Enteral feeding supply kit, pump fed, per day (1 unit = 1 day)	1 per day	Y	Purchase
B9000	EP		Enteral nutrition infusion pump – without alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
B9002	EP		Enteral nutrition infusion pump – with alarm (1 day = 1 unit)	1 per day	Y	Rent to Purchase
K0739	EP	U2	⁂(Repair or non-routine service for enteral nutrition infusion pump, requiring the skill of a technician, parts and labor)		Y	

Enteral Nutrition Infusion Pump

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid.

Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes ~~B9000 and B9002~~ represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan.

Codes ~~B9000 and B9002~~ are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day.

Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for codes ~~B9000 and B9002~~. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See Section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

242.153 Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and Low-Profile Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages

~~12-1-2010-~~ 1-221

NOTE: When billing for the Low-Profile Percutaneous Cecostomy Tube or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and service.

~~National Procedure Code~~	~~M1~~	~~M2~~	~~PA~~	~~Description~~	~~Payment Method~~
~~B9998~~			~~Y~~	~~Low Profile Kit~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U1~~	~~Y~~	~~SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 12" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U2~~	~~Y~~	~~SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 24" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U3~~	~~Y~~	~~Bolus Extension Set with Single Port Clamp 12" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U4~~	~~Y~~	~~Bolus Extension Set with Single Port Clamp 24" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U5~~	~~Y~~	~~Bolus SECUR-LOK Extension Set Single Port w/Clamp 12" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U6~~	~~Y~~	~~Bolus SECUR-LOK Extension Set Single Port w/Clamp 24" Length~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U7~~	~~Y~~	~~Microvasive Adapter~~	~~Purchase~~
~~B9998~~	~~NU~~	~~U8~~	~~Y~~	~~Microvasive Decompression Tube~~	~~Purchase~~

242.154 Nasogastric Tubing for Individuals Under Age 21

~~11-1-1710-~~ 1-221

The procedure code found in this section must be billed with modifier **EP** for beneficiaries under 21 years of age. The code is payable only for beneficiaries under age 21.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

National Procedure Code	M1	M2	PA	Description	Payment Method
B4082	EP		N	Nasogastric tubing without stylet	Purchase

242.155 Billing and Reimbursement Protocol for FM (Frequency Modulation) System and Replacement Cochlear Implant Parts

11-1-1710-1-221

Procedure codes L8621, L8622 and L8624 in the table below require paper claim submission with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. Procedure codes L8615, L8616, L8617, L8618, L8619, L8623, L8627, L8628 and L8629 may be submitted electronically or on a paper claim form. Procedure code V5273 may be submitted electronically or on a paper claim form. For provider charges for an FM system that is meant to be used with a cochlear implant, V5273 should reflect the retail price. For reimbursement of an FM system to be used with a cochlear implant, V5273 will be at 68 percent of the retail price.

National Procedure Code	M1	Description	PA	PA Criteria	Units Allowed per Date of Service
L8615*	EP	Headset/headpiece for use with cochlear implant device, replacement	Y	1 per 3 years	2
L8616*	EP	Microphone for use with cochlear implant device, replacement	Y	1 per year	2
L8617*	EP	Transmitting coil for use with cochlear implant device, replacement	Y	1 per year	2
L8618*	EP	Transmitter cable for use with cochlear implant device, replacement	Y	4 per 6 months	8
L8619*	EP	Cochlear implant external speech processor, and controller, integrated system, replacement	Y	5 years	2
L8621*	EP	Zinc air battery for use with cochlear implant device replacement, each	Y	180 units per 6 months	360
L8622*	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each	Y	180 units per 6 months	360

National Procedure Code	M1	Description	PA	PA Criteria	Units Allowed per Date of Service
L8623*	EP	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Y	1 (set of 2) per year Unilateral	2
L8624*	EP	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	Y	1 (set of 2) per year Unilateral	2
L8627*	EP	Cochlear implant, external speech processor, component, replacement	Y	Prior authorized when not under warranty	2
L8628*	EP	Cochlear implant, external controller component, replacement	Y	Prior authorized when not under warranty	2
L8629*	EP	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	Y	1 per year	2
V5273	EP	Assistive listening device, for use with cochlear implant	Y	Prior authorized when not covered through IDEA	1

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

*Denotes paper claim

242.160 Durable Medical Equipment, All Ages

11-1-1710-1-221

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**. Modifier **UE** is required when billing for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

* The purchase of wheelchairs for individuals age 21 and older is limited to one per five-year period.

*** This procedure code may not be billed for used equipment.

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

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

3 This item is a capped rental for 90 days only, and requires PA and a review.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
A4566	NU EP			N	Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment	Manually Priced
A4635	NU EP UE			N	Underarm pad, crutch, replacement, each	Purchase
A4636	NU EP UE			N	Replacement, handgrip, cane, crutch, or walker, each	Purchase
A4637	NU EP UE			N	Replacement, tip, cane, crutch, walker, each	Purchase
A7020	NU EP			Y	Interface for cough stimulating device, includes all components, replacement only	Manually Priced
A9999	NU			Y	⁂(Unlisted Durable Medical Equipment. **The manufacturer's invoice must be attached to the claim form.)** Misc. DME supply or accessory, not otherwise specified	Purchase
E0100	NU EP UE			N	Cane, includes canes of all materials, adjustable or fixed, with tip	Purchase
E0105	NU EP UE			N	Cane, quad or three-prong, includes canes of all materials, adjustable or fixed, with tips	Purchase
E0110	NU EP UE			N	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips	Purchase
E0111	NU EP UE			N	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0111	NU	U1		N	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip	Purchase
E0112	NU EP UE			N	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips	Purchase
E0113	NU EP UE			N	Crutch, underarm, wood, adjustable or fixed, each, with pad, tip and handgrip	Purchase
E0114	NU EP UE			N	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips	Purchase
E0116	NU EP UE			N	Crutch, underarm, other than wood, adjustable or fixed, each, with pad, tip and handgrip	Purchase
E0130	NU EP UE			N	Walker, rigid (pickup), adjustable or fixed height	Purchase
E0135	NU EP UE			N	Walker, folding (pickup), adjustable or fixed height	Purchase
E0140	NU EP			N	Walker, w/trunk support, adjustable or fixed height, any type	Purchase
E0141	NU EP UE			N	Walker, rigid, wheeled, adjustable or fixed height	Purchase
E0143	NU EP UE			N	Walker, folding, wheeled, adjustable or fixed height	Purchase
E0147	NU EP UE			N	Walker, heavy-duty, multiple braking system, variable wheel resistance	Purchase
E0153	NU EP UE			N	Platform attachment, forearm crutch, each	Purchase
E0154	NU EP UE			N	Platform attachment, walker, each	Purchase
E0155	NU EP UE			N	Wheel attachment, rigid pick-up walker, per pair seat attachment, walker	Purchase
E0156	NU EP			N	Seat attachment, walker	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0157	NU EP UE			N	Crutch attachment, walker, each	Purchase
E0158	NU EP UE			N	Leg extensions for walker, per set of four (4)	Purchase
E0159	NU EP			N	Brake attachment for wheeled walker, replacement, each	Purchase
E0160	NU EP UE			N	Sitz type bath or equipment, portable, used with or without commode	Purchase
E0161	NU EP UE			N	Sitz type bath or equipment, portable, used with or without commode, with faucet attachment(s)	Purchase
E0163	NU EP UE			N	Commode chair, stationary, with fixed arms	Purchase
E0167	NU EP UE			N	Pail or pan for use with commode chair	Purchase
E0175	NU EP UE			N	Foot rest, for use with commode chair, each	Purchase
E0181	NU EP UE			N	Pressure pad, alternating with pump, heavy-duty	Capped Rental
E0182	NU EP UE			N	Pump for alternating pressure pad	Purchase
E0184	NU EP UE			N	Dry pressure mattress	Purchase
E0185	NU EP UE			N	Gel or gel-like pressure pad for mattress, standard mattress length and width	Purchase
E0186	NU EP			Y	Air pressure mattress	Purchase
E0187	NU EP			Y	Water pressure mattress	Purchase
E0189	NU EP UE			N	Lamb's wool sheepskin pad, any size	Purchase
E0190	NU UE			N	Positioning cushion/pillow/wedge, any shape or size	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0190	EP			N	⁂ (Tumble Form Therapy Roll 4“) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U1		N	⁂ (Tumble Form Therapy Roll 6”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U2		N	⁂ (Tumble Form Therapy Wedge 4”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U3		N	⁂ (Tumble Form Therapy Roll 8”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U4		N	⁂ (Tumble Form Therapy Wedge 6”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U5		N	⁂ (Floor Sitter Wedge 4”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U6		N	⁂ (Tumble Form Therapy Roll 12”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U7		N	⁂ (Deluxe Wedge with strap 4”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U8		N	⁂ (Deluxe Wedge with strap 6”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	U9		N	⁂ (Tumble Form Therapy Wedge 10”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	KA	U1	N	⁂ (Tumble Form Therapy Roll 14”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0190	EP	KA	U2	N	(Tumble Form Therapy Roll 16”) Positioning cushion/pillow/wedge, any shape or size ⁂	Purchase
E0190	EP	KA	U3	N	⁂ (Tumble Form Therapy Wedge 8”) Positioning cushion/pillow/wedge, any shape or size	Purchase
E0191	NU EP UE			N	Heel or elbow protector, each	Purchase
E0194[3]	NU EP			Y	⁂(Clinitron Bed) Air fluidized bed	Capped Rental

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0196	NU EP			N	Gel pressure mattress	Purchase
E0197	NU EP UE			N	Air pressure pad for mattress, standard mattress length and width	Purchase
E0198	NU EP			Y	Water pressure pad for mattress, standard mattress length and width	Purchase
E0200	NU EP UE			N	Heat lamp, without stand (table model), includes bulb, or infrared element	Capped Rental
E0202	NU EP UE			N	Phototherapy (bilirubin) light with photometer	Rental Only
E0202	UE	U1		N	Phototherapy (bilirubin) light with photometer	Capped Rental
E0205	NU EP UE			N	Heat lamp, with stand includes bulb, or infrared element	Capped Rental
E0217	NU EP UE			N	Water circulating heat pad with pump	Capped Rental
E0225	NU EP UE			N	Hydrocollator unit, includes pad	Capped Rental
E0235	NU EP UE			N	Paraffin bath unit, portable (see medical supply code A4265 for paraffin)	Purchase
E0236	NU EP UE			N	Pump for water circulating pad	Capped Rental
E0239	NU EP UE			N	Hydrocollator unit, portable	Capped Rental
E0240	NU EP			N	Bath/shower chair w/wo wheels, any size	Purchase
E0240	NU EP	U1 U1		N	Bath/shower chair w/wo wheels, any size	Purchase
E0240	NU EP	U2 U2		N	Bath/shower chair w/wo wheels, any size	Purchase
E0240	NU EP	U3 U3		N	Bath/shower chair w/wo wheels, any size	Purchase
E0244	NU EP			N	Raised toilet seat	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0245***	NU EP	U1 U1		N	**(Bath Frame Support, Large) Tub stool or bench	Purchase
E0247	NU EP			N	Transfer bench, tub/toilet, w/wo commode opening	Purchase
E0247	NU EP	U1 U1		N	Transfer bench, tub/toilet, w/wo commode opening	Purchase
E0248	NU EP			N	Transfer bench, heavy duty, tub/toilet w/wo commode opening	Purchase
E0248	NU EP	U1 U1		N	Transfer bench, heavy duty, tub/toilet w/wo commode opening	Purchase
E0249	NU EP UE			N	Pad for water circulating heat unit	Purchase
E0250	NU EP			Y♦	**(Hospital bed, with side rails, fixed height, with mattress, purchase) Hospital bed, fixed height, with any type side rails, with mattress	Purchase
E0250	NU EP	RR RR		Y♦	Hospital bed, fixed height, with any type side rails, with mattress	Capped Rental
E0255	NU EP			Y♦	Hospital bed, variable height; hi-lo, with any type side rails, with mattress	Purchase
E0255	NU EP	RR RR		Y♦	Hospital bed, variable height; hi-lo, with any type side rails, with mattress	Capped Rental
E0255	NU	U1		Y♦	**(Hospital bed, with side rails, variable height; hi-lo, with mattress, purchase) Hospital bed, variable height; hi-lo, with any type side rails, with mattress	Purchase
E0255	UE			Y♦	Hospital bed, variable height; hi-lo, with any type side rails, with mattress	Capped Rental
E0260	NU EP UE			Y♦	**(Hospital bed, with side rails, semi-electric, head and foot adjustments, with mattress, purchase) Hospital bed, semi-electric, head and foot adjustment, with any type side rails with mattress	Purchase
E0260	NU EP	RR RR		Y♦	Hospital bed, semi-electric, head and foot adjustment, with any type side rails with mattress	Capped Rental
E0271	NU EP UE			N	Mattress, inner spring	Capped Rental

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0272	NU EP UE			N	Mattress, foam rubber	Capped Rental
E0273	NU EP UE			N	Bed board	Purchase
E0275	NU EP UE			N	Bed pan, standard, metal or plastic	Purchase
E0276	NU EP UE			N	Bed pan, fracture, metal or plastic	Purchase
E0277[3]	NU EP			Y	⁂(Low Air Loss Mattress) Powered pressure-reducing air mattress	Capped Rental
E0280	NU EP UE			N	Bed cradle, any type	Purchase
E0300	EP			Y	Pediatric crib, hospital grade, fully enclosed	Purchase
E0300	EP	RR		Y	Pediatric crib, hospital grade, fully enclosed	Rental Only
E0302	NU EP			Y Y	Hospital bed, heavy-duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress	Capped Rental
E0303	NU EP UE			Y Y Y	Hospital bed, heavy-duty, extra wide, with weight capacity > 350 but < or = 600, any type side rails, w/mattress	Rental Only (Rent to Purchase)
E0304	NU EP			Y Y	Hospital bed, extra heavy-duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress	Capped Rental
E0325	NU EP UE			N	Urinal; male, jug-type, any material	Purchase
E0325	NU EP UE	U1 U1 U1		N	Urinal; male, jug-type, any material	Purchase
E0326	NU EP UE			N	Urinal; female, jug-type, any material	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0445***	NU EP			Y♦	**(Pulse oximeter, including 4 disposable probes) Oximeter for measuring blood oxygen levels non-invasively	Rental Only
E0480	NU EP UE			N	Percussor, electric or pneumatic, home model	Capped Rental
E0565	NU EP UE			Y♦	Compressor, air power source for equipment which is not self-contained or cylinder driven	Capped Rental
E0570	NU UE			Y	Nebulizer, with compressor	Purchase
E0585	NU EP UE			N	Nebulizer, with compressor and heater	Capped Rental
E0605	NU EP UE			N	Vaporizer, room type	Purchase
E0606	NU EP UE			N	Postural drainage board	Capped Rental
E0607***	NU EP			N	Home blood glucose monitor	Purchase
E0621	NU			N	Sling or seat, patient lift, canvas or nylon	Purchase
E0630	NU EP UE			Y♦	Patient lift, hydraulic, with seat or sling	Capped Rental
E0650	NU EP UE			Y♦	Pneumatic compressor, nonsegmental home model	Capped Rental
E0667	NU EP			Y♦	Segmental pneumatic appliance for use with pneumatic compressor, full leg	Capped Rental
E0668	NU EP			Y♦	Segmental pneumatic appliance for use with pneumatic compressor, full arm	Capped Rental
E0670	NU EP			N	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk	Purchase
E0691	NU EP			N	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less	Rental Only

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0692	NU EP			N	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; four foot panel	Rental Only
E0693	NU EP			N	Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; six foot panel	Rental Only
E0694	NU EP			N	Ultraviolet multidirectional light therapy system in six foot cabinet includes bulbs/lamps, timer and eye protection	Rental Only
E0720	NU EP UE			Y♦	TENS, two lead, localized stimulation	Capped Rental
E0730	NU EP UE			Y♦	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation	Capped Rental
E0740	NU EP UE			N	Incontinence treatment system, pelvic floor stimulator, monitor, sensor and/or trainer	Purchase
E0745	NU EP UE			Y♦	Neuromuscular stimulator, electronic shock unit	Capped Rental
E0747	NU EP UE			Y♦	Osteogenesis stimulator, electrical noninvasive, other than spinal applications	Rental Only
E0748	NU EP			Y	Osteogenesis stimulator, electrical noninvasive, spinal applications	Rental Only
E0760	NU EP			Y	Osteogenesis stimulator, low intensity ultrasound, noninvasive	Rental Only
E0779	NU	RR		Y♦	**(Ambulatory infusion device, payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home) Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater	Rental Only
E0840	NU EP UE			N	Traction frame, attached to headboard, cervical traction	Purchase
E0850	NU EP UE			N	Traction stand, freestanding, cervical traction	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0860	NU EP UE			N	Traction equipment, overdoor, cervical	Purchase
E0870	NU EP UE			N	Traction frame, attached to footboard, extremity traction (e.g., Buck's)	Purchase
E0880	NU EP UE			N	Traction stand, freestanding, extremity traction (e.g., Buck's)	Purchase
E0890	NU EP UE			N	Traction frame, attached to footboard, pelvic traction	Purchase
E0900	NU EP UE			N	Traction stand, freestanding, pelvic traction (e.g., Buck's)	Purchase
E0910	NU EP UE			N	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	Capped Rental
E0910	NU	RR		N	Trapeze bars, also known as Patient Helper, attached to bed, with grab bar	Capped Rental
E0920	NU EP UE			N	Fracture frame, attached to bed, includes weights	Capped Rental
E0930	NU EP UE			N	Fracture frame, freestanding, includes weights	Capped Rental
E0935	NU EP UE			Y♦	Continuous passive motion exercise device for use on knee only	Capped Rental
E0940	NU EP UE			N	Trapeze bar, freestanding, complete with grab bar	Capped Rental
E0941	NU EP UE			N	Gravity assisted traction device, any type	Capped Rental
E0942	NU EP UE			N	Cervical head harness/halter	Purchase
E0944	NU EP UE			N	Pelvic belt/harness/boot	Purchase
E0945	NU EP UE			N	Extremity belt/harness	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
E0946	NU EP UE			N	Fracture frame, dual with cross bars, attached to bed (e.g., Balken, Four Poster)	Purchase
E0947	NU EP UE			N	Fracture frame, attachments for complex pelvic traction	Purchase
E0948	NU EP UE			N	Fracture frame, attachments for complex cervical traction	Purchase
E0950	NU EP UE			N	Wheelchair accessory, tray, each	Purchase
E1036	NU EP			Y	Multi-positional patient transfer system, with integrated seat, operated by care giver; patient weight capacity up to and including 300 lbs	Purchase
E1130*	NU EP UE			Y♦	Standard wheelchair, fixed full-length arms, fixed or swing-away, detachable footrests	Capped Rental
E1130*	NU	U1		Y♦	Standard wheelchair, fixed full-length arms, fixed or swing-away, detachable footrests	Rental Only
E1140*	NU EP			Y♦	Wheelchair, detachable arms, desk or full-length, swing-away, detachable footrests	Capped Rental
E1150*	NU EP			Y♦	Wheelchair; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	Capped Rental
E1160*	NU EP			Y♦	Wheelchair; fixed full-length arms, swing-away, detachable, elevating leg rests	Capped Rental
E1224*	NU EP UE			Y♦	Wheelchair with detachable arms, elevating leg rests	Capped Rental
E1224*	NU	U1		Y♦	⁂(Footrests wheelchair with detachable arms, elevating leg rests) Wheelchair with detachable arms, elevating leg rests	Rental Only
E1399	NU			N	Durable medical equipment, miscellaneous	Manually Priced
K0105	NU EP			N	IV hanger, each	Purchase

Durable Medical Equipment, All Ages (Section 242.160)

National Procedure Code	M1	M2	M3	PA	Description	Payment Method
K0606	NU EP			Y	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type (covered only for beneficiaries ages 18 and over)	Capped Rental
K0739	NU			N	**(DME Repair, Parts only. Repairs will not be approved for more than the allowed purchase price of new equipment. The manufacturer's invoice must be attached to the repair claim for all parts.)	Manually Priced
K0739	NU	U4		N	**(Maintenance for Capped Rental items) Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes	Manually Priced
K0739	NU EP	U1 U1		N	**(Labor only, Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable, 20 units=5 hours of labor)	Manually Priced
K0739	NU EP	U3 U3		N	**(Unlisted Repairs/Parts Only wheelchairs; applicable pages from the manufacturer's catalog must be attached to the claim form. Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.)	Manually Priced
S8096***	NU EP			N	**(Peak flow meter used by asthmatic patients) Portable peak flow meter	Purchase

Procedure codes **E0250♦**, **E0255♦** and **E0260♦** must be billed when hospital beds are purchased for Medicaid beneficiaries of all ages. Providers must only provide these purchase-only services to beneficiaries who are expected to require the bed for a long period of time. **Each procedure code for hospital beds listed above may only be billed once every 10 years.**

Procedure codes **E0250♦**, **E0255♦** and **E0260♦** must also be used to bill for equipment that does not meet the purchase-only criteria. They are reimbursed on a capped rental basis. The capped rental items must be used until the equipment is no longer repairable or until it is no longer appropriate for the beneficiary as verified by the physician.

242.170 Apnea Monitors for Beneficiaries Under 1 Year of Age

~~5-22-19~~10-1-~~22~~4

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age. Modifier **UE** must be used to bill for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Sections 212.300 and 222.200 contain information regarding specific coverage and restrictions.

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

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~	~~Deleted Local Code~~
~~E0619~~			~~⁂(Initial setup of Apnea monitor, includes 60 days rental) Apnea monitor, with recording feature~~	~~N~~	~~First 60 Days Rental~~	~~N/A~~
~~E0619~~	~~EP~~		~~Apnea monitor, with recording feature~~	~~Y (on 61st day)♦~~	~~Rental Only (Daily Rental)~~	~~N/A~~
~~E0619~~	~~EP~~	~~U1~~	~~Technician and Lab Processing for setting up Pneumogram or event~~	~~N~~	~~Purchase~~	~~Z1684~~

242.180 Orthotic Appliances for Beneficiaries of All Ages

~~8-15-18~~10-1-~~22~~4

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for individuals age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown. When prior authorization is not applicable (for U21) that information is shown with an "N/A" in the column.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for individuals under age 21 and "21+" is shown when the code is payable only for those individuals age 21 and older.

** This item is not a covered service for the diagnosis of Carpal Tunnel Syndrome prior to surgery.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

■ This procedure code does not require prior authorization; however, the beneficiary's medical condition must fall within the following diagnosis codes. **(View ICD codes.)**

\+ This item is limited to one every twelve months for beneficiaries age 21 and over.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~**Orthotic Appliances, All Ages (Section 242.180)**~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~All U21 21+~~	~~PA 21+~~	~~Payment Method~~
~~A5500■~~	~~NU~~		~~For diabetics only, fitting (including follow-up) custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5501■~~	~~NU~~		~~For diabetics only, fitting (including follow-up) custom preparation and supply of molded from cast(s) of patient's foot (custom molded shoe), per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5503■~~	~~NU~~		~~For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with roller or rigid rocker bottom, per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5504■~~	~~NU~~		~~For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with wedge(s), per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5505■~~	~~NU~~		~~For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with metatarsal bar, per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5506■~~	~~NU~~		~~For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe with off-set heel(s), per shoe~~	~~21+~~	~~N~~	~~Purchase~~
~~A5507~~	~~NU~~		~~For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom molded shoe, per shoe~~	~~21+~~	~~Y~~	~~Purchase~~
~~A5510■~~	~~NU~~		~~For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe~~	~~21+~~	~~N~~	~~Purchase~~

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
A5512■	NU		For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees Fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer of 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each	21+	N	Purchase
A5513■	NU		For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer or higher, includes arch filler and other shaping material custom fabricated, each	21+	N	Purchase
E1810	NU EP		Dynamic adjustable knee extension/flexion device, includes soft interface material	All	N	Purchase
K0672	NU EP		Addition to lower extremity orthotic, removable soft interface, all components, replacement only, each.	All	N	Purchase
L0120	NU EP		Cervical, flexible, nonadjustable (foam collar)	All	N	Purchase
L0130	NU EP		Cervical, flexible, thermoplastic collar, molded to patient	All	N	Purchase
L0140	NU EP		Cervical, semi-rigid, adjustable (plastic collar)	All	N	Purchase
L0150	NU EP		Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)	All	N	Purchase
L0160	NU EP		Cervical, semi-rigid, wire frame occipital/mandibular support	All	N	Purchase
L0170	NU EP		Cervical, collar, molded to patient model	All	N	Purchase
L0172	NU EP		Cervical, collar, semi-rigid thermoplastic foam, two piece	All	N	Purchase
L0174	NU EP		Cervical, collar, semi-rigid thermoplastic foam, two piece with thoracic extension	All	N	Purchase
L0180	NU EP		Cervical, multiple post collar, occipital/mandibular supports, adjustable	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0190	NU EP		Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (SOMI, Guilford, Taylor types)	All	N	Purchase
L0200	NU EP		Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension	All	N	Purchase
L0220	NU EP		Thoracic, rib belt, custom fabricated	All	N	Purchase
L0450	NU EP		TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment	All	N	Purchase
L0452	NU EP		TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated	All	N	Purchase
L0454	NU EP		TLSO, flexible, provides trunk support, extends from sacrococcygeal junction to above T-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, includes fitting and adjustment	All	N	Purchase
L0456	NU EP		TLSO, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, includes fitting and adjustment	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0458	NU EP		TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment	All	Y	Purchase
L0460	NU EP		TLSO, triplanar control modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, including straps and closures, prefabricated, includes fitting and adjustment	All	Y	Purchase
L0462	NU EP		TLSO, triplanar control modular segmented spinal system, three rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, including straps and closures, prefabricated, includes fitting and adjustment	All	Y	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0464	NU EP		TLSO, triplanar control modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, including straps and closures, prefabricated, includes fitting and adjustment	All	Y	Purchase
L0466	NU EP		TLSO, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	All	N	Purchase
L0468	NU EP		TLSO, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	All	N	Purchase
L0470	NU EP		TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal and transverse planes, produces intracavitary pressure to reduce load on intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0472	NU EP		TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from symphysis pubis to sternal notch with two anterior components (one pubic and one sternal) posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment	All	N	Purchase
L0480	NU EP		TLSO, triplanar control, one-piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated	All	Y	Purchase
L0482	NU EP		TLSO, triplanar control, one-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated	All	Y	Purchase
L0484	NU EP		TLSO, triplanar control, two-piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated	All	Y	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0486	NU EP		TLSO, triplanar control, two-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal and transverse planes, includes a carved plaster or CAD-CAM model, custom fabricated	All	Y	Purchase
L0488	NU EP		TLSO, triplanar control, one-piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal and transverse planes, prefabricated, includes fitting and adjustment	All	Y	Purchase
L0490	NU EP		TLSO, sagittal-coronal control, one-piece rigid plastic shell with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment	All	Y	Purchase
L0621	NU EP		Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0622	NU EP		Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0623	NU EP		Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0624	NU EP		Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated	All	N	Manually Priced
L0625	NU EP		Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment	All	N	Purchase
L0626	NU EP		Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0627	NU EP		Lumbar orthosis, sagittal control, with rigid anterior and posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0628	NU EP		Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0629	NU EP		Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom fabricated	All	N	Manually Priced
L0630	NU EP		Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0631	NU EP		Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0632	NU EP		Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated	All	N	Manually Priced

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0633	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0634	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated	All	N	Manually Priced
L0635	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0636	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0637	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0638	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated	All	N	Purchase
L0639	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment	All	N	Purchase
L0640	NU EP		Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xiphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L0700	NU EP		Cervical-thoracic-lumbar-sacral orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model (Minerva type)	All	Y	Purchase
L0710	NU EP		CTLSO, anterior-posterior-lateral control, molded to patient model, with interface material (Minerva type)	All	Y	Purchase
L0810	NU EP		Halo procedure, cervical halo incorporated into jacket vest	All	Y	Purchase
L0820	NU EP		Halo procedure, cervical halo incorporated into plaster body jacket	All	Y	Purchase
L0830	NU EP		Halo procedure, cervical halo incorporated into Milwaukee type orthosis	All	Y	Purchase
L0859	NU EP		Addition to halo procedure, magnetic resonance image compatible system, rings and pins, any material	All	Y	Purchase
L0970	NU EP		TLSO, corset front	All	N	Purchase
L0972	NU EP		LSO, corset front	All	N	Purchase
L0974	NU EP		TLSO, full corset	All	N	Purchase
L0976	NU EP		LSO, full corset	All	N	Purchase
L0978	NU EP		Axillary crutch extension	All	N	Purchase
L0980	NU EP		Peroneal straps, pair	All	N	Purchase
L0982	NU EP		Stocking supporter grips, set of four (4)	All	N	Purchase
L0984	NU		Protective body sock, each	21+	N	Purchase
L1000	NU EP		CTLSO (Milwaukee), inclusive of furnishing initial orthosis, including model	All	Y	Purchase
L1010	NU EP		Addition to CTLSO or scoliosis orthosis, axilla sling	All	N	Purchase
L1020	NU EP		Addition to CTLSO or scoliosis orthosis, kyphosis pad	All	N	Purchase
L1025	NU EP		Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1030	NU EP		Addition to CTLSO or scoliosis orthosis, lumbar bolster pad	All	N	Purchase
L1040	NU EP		Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad	All	N	Purchase
L1050	NU EP		Addition to CTLSO or scoliosis orthosis, sternal pad	All	N	Purchase
L1060	NU EP		Addition to CTLSO or scoliosis orthosis, thoracic pad	All	N	Purchase
L1070	NU EP		Addition to CTLSO or scoliosis orthosis, trapezius sling	All	N	Purchase
L1080	NU EP		Addition to CTLSO or scoliosis orthosis, outrigger	All	N	Purchase
L1085	NU EP		Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions	All	N	Purchase
L1090	NU EP		Addition to CTLSO or scoliosis orthosis, lumbar sling	All	N	Purchase
L1100	NU EP		Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather	All	N	Purchase
L1110	NU EP		Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model	All	N	Purchase
L1120	NU EP		Addition to CTLSO, scoliosis orthosis, cover for upright, each	All	N	Purchase
L1200	NU EP		Thoracic lumbar sacral orthosis (TLSO), inclusive of furnishing initial orthosis only	All	Y	Purchase
L1210	NU EP		Addition to TLSO (low profile), lateral thoracic extension	All	N	Purchase
L1220	NU EP		Addition to TLSO (low profile), anterior thoracic extension	All	N	Purchase
L1230	NU EP		Addition to TLSO (low profile), Milwaukee type superstructure	All	N	Purchase
L1240	NU EP		Addition to TLSO (low profile), lumbar derotation pad	All	N	Purchase
L1250	NU EP		Addition to TLSO (low profile), anterior ASIS pad	All	N	Purchase
L1260	NU EP		Addition to TLSO (low profile), anterior thoracic derotation pad	All	N	Purchase
L1270	NU EP		Addition to TLSO (low profile), abdominal pad	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1280	NU EP		Addition to TLSO (low profile), rib gusset (elastic), each	All	N	Purchase
L1290	NU EP		Addition to TLSO (low profile), lateral trochanteric pad	All	N	Purchase
L1300	NU EP		Other scoliosis procedure, body jacket molded to patient model	All	Y	Purchase
L1310	NU EP		Other scoliosis procedure, post-operative body jacket	All	Y	Purchase
L1499	NU EP		Spinal orthosis, not otherwise specified. ⁂**(The manufacturer's invoice must be attached to all claims.)**	All	Y	Manually Priced
L1600	NU EP		HO, abduction control of hip joints, flexible, Frejka type with cover, prefabricated, includes fitting and adjustment	All	N	Purchase
L1610	NU EP		HO, abduction control of hip joints, flexible (Frejka cover only), prefabricated, includes fitting and adjustment	All	N	Purchase
L1620	NU EP		HO, abduction control of hip joints, flexible (Pavlik harness), prefabricated, includes fitting and adjustment	All	N	Purchase
L1630	NU EP		HO, abduction control of hip joints, semi-flexible (Von Rosen type), custom fabricated	All	N	Purchase
L1640	NU EP		HO, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated	All	N	Purchase
L1650	NU EP		HO, abduction control of hip joints, static, adjustable, custom fitted (Ilfled type), prefabricated, includes fitting and adjustment	All	N	Purchase
L1660	NU EP		HO, abduction control of hip joints, static, plastic, prefabricated, includes fitting and adjustment	All	N	Purchase
L1680	NU EP		HO; abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (Rancho hip action type), custom fabricated	All	Y	Purchase
L1685	NU EP		HO, abduction control of hip joint, post operative hip abduction type, custom fabricated	All	Y	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1686	NU EP		HO, abduction control of hip joint, post operative hip abduction type, prefabricated, includes fitting and adjustments	All	Y	Purchase
L1690	NU EP		Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, prefabricated, includes fitting and adjustment	All	Y	Purchase
L1700	NU EP		Legg Perthes orthosis (Toronto type), custom fabricated	All	Y	Purchase
L1710	NU EP		Legg Perthes orthosis (Newington type), custom fabricated	All	Y	Purchase
L1720	NU EP		Legg Perthes orthosis, trilateral (Tachdijan type), custom fabricated	All	Y	Purchase
L1730	NU EP		Legg Perthes orthosis (Scottish Rite type) custom fabricated	All	Y	Purchase
L1755	NU EP		Legg Perthes orthosis (Patten bottom type), custom fabricated	All	Y	Purchase
L1810	NU EP		KO, elastic with joints, prefabricated, includes fitting and adjustment	All	N	Purchase
L1820	NU EP		KO, elastic with condylar pads and joints, prefabricated, includes fitting and adjustment	All	N	Purchase
L1830	NU EP		KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment	All	N	Purchase
L1832	NU EP		Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, includes fitting and adjustment	All	N	Purchase
L1834	NU EP		KO, without knee joint, rigid, custom fabricated	All	N	Purchase
L1840	NU EP		KO, derotation, medial-lateral, anterior cruciate ligament, custom fabricated	All	Y	Purchase
L1843	NU		Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment	21+	Y	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1844	NU		Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated	21+	Y	Purchase
L1845	NU EP		Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control with or without varus/valgus adjustment, prefabricated, includes fitting and adjustment	All	Y	Purchase
L1846	NU EP		Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control with or without varus/valgus adjustment, custom fabricated	All	Y	Purchase
L1847	NU		Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s) prefabricated, includes fitting and adjustment	21+	N	Purchase
L1850	NU EP		KO, Swedish type, prefabricated, includes fitting and adjustment	All	N	Purchase
L1851	NU EP		Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf	All	N	Purchase
L1852	NU EP		Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf	All	Y	Purchase
L1860	NU EP		KO, modification of supracondylar prosthetic socket, custom fabricated (SK)	All	Y	Purchase
L1900	NU EP		AFO, spring wire, dorsiflexion assist calf band, custom fabricated	All	N	Purchase
L1902	NU EP		AFO, ankle gauntlet, prefabricated, includes fitting and adjustment	All	N	Purchase
L1904	NU EP		AFO, molded ankle gauntlet, custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1906	NU EP		AFO, multiligamentus ankle support, prefabricated, includes fitting and adjustment	All	N	Purchase
L1907	NU EP		AFO, supramalleolar with straps, with or without interface/pads, custom fabricated	All	N	Purchase
L1910	NU EP		AFO, posterior, single bar, clasp attachment to shoe counter prefabricated, includes fitting and adjustment	All	N	Purchase
L1920	NU EP		**(Custom night "A" frame-KAFO, torsion control, bilateral night "A" frame) AFO, single upright with static or adjustable stop (Phelps or Perlstein type), custom fabricated	All	N	Purchase
L1930	NU EP		AFO, plastic or other material, prefabricated, includes fitting and adjustment	All	N	Purchase
L1932	NU EP		AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment	All	N	Purchase
L1940	NU EP		AFO, plastic or other material, custom-fabricated	All	N	Purchase
L1945	NU EP		AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction), custom fabricated	All	Y	Purchase
L1950	NU EP		AFO, spiral (Institute of Rehabilitative Medicine type), plastic, custom fabricated	All	N	Purchase
L1951	NU EP		Ankle foot orthosis, spiral (Institute of Rehabilitative Medicine type), plastic, or other material, prefabricated, includes fitting and adjustment	All	N	Purchase
L1960	NU EP		AFO, posterior solid ankle, plastic, custom fabricated	All	N	Purchase
L1970	NU EP		AFO, plastic, with ankle joint, custom fabricated	All	N	Purchase
L1980	NU EP		AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar BK orthosis), custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L1990	NU EP		AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar BK orthosis), custom fabricated	All	N	Purchase
L2000	NU EP		KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK orthosis), custom fabricated	All	Y	Purchase
L2005	NU EP		KAFO, any material, single or double upright, stance control, automatic lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated	All	N	Purchase
L2010	NU EP		KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar AK orthosis), without knee joint, custom fabricated	All	Y	Purchase
L2020	NU EP		KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar AK orthosis), custom fabricated	All	Y	Purchase
L2030	NU EP		KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar AK orthosis), without knee joint, custom fabricated	All	Y	Purchase
L2035	NU		Knee ankle foot orthosis, full plastic, static (pediatric size) without free motion ankle, prefabricated, includes fitting and adjustment	21+	N	Purchase
L2036	NU EP		Knee ankle foot orthosis, full plastic, double upright, with or without free motion knee, with or without free motion ankle, custom fabricated	All	Y	Purchase
L2037	NU EP		Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated	All	Y	Purchase
L2038	NU EP		Knee ankle foot orthosis, full plastic, with or without free motion knee , multi-axis ankle, custom fabricated	All	Y	Purchase
L2040	NU EP		HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2040	NU EP	U1 U1	**(Night "A" frame-KAFO, torsion control, bilateral night "A" frame) HKAFO, torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated	All	N	Manually Priced Purchase
L2050	NU EP		HKAFO, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated	All	N	Purchase
L2060	NU EP		HKAFO, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/belt, custom fabricated	All	N	Purchase
L2070	NU EP		HKAFO, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated	All	N	Purchase
L2080	NU EP		HKAFO, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated	All	N	Purchase
L2090	NU EP		HKAFO, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/belt, custom fabricated	All	N	Purchase
L2106	NU EP		AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated	All	N	Purchase
L2108	NU EP		AFO, fracture orthosis, tibial fracture cast orthosis, custom fabricated	All	Y	Purchase
L2112	NU EP		AFO, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment	All	N	Purchase
L2114	NU EP		AFO, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment	All	N	Purchase
L2116	NU EP		AFO, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment	All	N	Purchase
L2126	NU EP		KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated	All	Y	Purchase
L2128	NU EP		KAFO, fracture orthosis, femoral fracture cast orthosis, custom fabricated	All	Y	Purchase
L2132	NU EP		KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment	All	Y	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2134	NU EP		KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid prefabricated, includes fitting and adjustment	All	Y	Purchase
L2136	NU EP		KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment	All	Y	Purchase
L2180	NU EP		Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints	All	N	Purchase
L2182	NU EP		Addition to lower extremity fracture orthosis, drop lock knee joint	All	N	Purchase
L2184	NU EP		Addition to lower extremity fracture orthosis, limited motion knee joint	All	N	Purchase
L2186	NU EP		Addition to lower extremity fracture orthosis, adjustable motion knee joint, Lerman type	All	N	Purchase
L2188	NU EP		Addition to lower extremity fracture orthosis, quadrilateral brim	All	N	Purchase
L2190	NU EP		Addition to lower extremity fracture orthosis, waist belt	All	N	Purchase
L2192	NU EP		Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt	All	N	Purchase
L2200	NU EP		Additions to lower extremity, limited ankle motion, each joint	All	N	Purchase
L2210	NU EP		Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint	All	N	Purchase
L2220	NU EP		Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint	All	N	Purchase
L2230	NU EP		Addition to lower extremity, split flat caliper stirrups and plate attachment	All	N	Purchase
L2232	NU EP		Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only	All	N	Manually Priced
L2240	NU EP		Addition to lower extremity, round caliper and plate attachment	All	N	Purchase
L2250	NU EP		Addition to lower extremity, foot plate, molded to patient model, stirrup attachment	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2260	NU EP		Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)	All	N	Purchase
L2265	NU EP		Addition to lower extremity, long tongue stirrup	All	N	Purchase
L2270	NU EP		Addition to lower extremity, varus/valgus correction (T) strap, padded/lined or malleolus pad	All	N	Purchase
L2275	NU EP		Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined	All	N	Purchase
L2280	NU EP		Addition to lower extremity, molded inner boot	All	N	Purchase
L2300	NU EP		Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable	All	N	Purchase
L2310	NU EP		Addition to lower extremity, abduction bar straight	All	N	Purchase
L2320	NU EP		Addition to lower extremity, nonmolded lacer, for custom fabricated orthosis only	All	N	Purchase
L2330	NU EP		Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only	All	N	Purchase
L2335	NU EP		Addition to lower extremity, anterior swing band	All	N	Purchase
L2340	NU EP		Addition to lower extremity, pretibial shell, molded to patient model	All	N	Purchase
L2350	NU EP		Addition to lower extremity, prosthetic type, (BK) socket, molded to patient model, (used for PTB, AFO orthoses)	All	Y	Purchase
L2360	NU EP		Addition to lower extremity, extended steel shank	All	N	Purchase
L2370	NU EP		Addition to lower extremity, Patten bottom	All	N	Purchase
L2375	NU EP		Addition to lower extremity, torsion control, ankle joint and half solid stirrup	All	N	Purchase
L2380	NU EP		Addition to lower extremity, torsion control, straight knee joint, each joint	All	N	Purchase
L2385	NU EP		Addition to lower extremity, straight knee joint, heavy-duty, each joint	All	N	Purchase
L2390	NU EP		Addition to lower extremity, offset knee joint, each joint	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2395	NU EP		Addition to lower extremity, offset knee joint, heavy-duty, each joint	All	N	Purchase
L2397	NU		Addition to lower extremity orthosis, suspension sleeve	21+	N	Purchase
L2405	NU EP		Addition to knee joint, drop lock, each	All	N	Purchase
L2415	NU EP		Addition to knee lock with integrated release mechanism , (bail, cable or equal, any material, each joint	All	N	Purchase
L2425	NU EP		Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint	All	N	Purchase
L2430	NU EP		Addition to knee joint, ratchet lock for active and progressive knee extension, each joint	All	N	Purchase
L2492	NU EP		Addition to knee joint, lift loop for drop lock ring	All	N	Purchase
L2500	NU EP		Addition to lower extremity, thigh/weight bearing, gluteal/ischial weight bearing, ring	All	N	Purchase
L2510	NU EP		Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, molded to patient model	All	N	Purchase
L2520	NU EP		Addition to lower extremity, thigh/weight bearing, quadri-lateral brim, custom fitted	All	N	Purchase
L2525	NU EP		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim molded to patient model	All	N	Purchase
L2526	NU EP		Addition to lower extremity, thigh/weight bearing, ischial containment/narrow M-L brim, custom fitted	All	N	Purchase
L2530	NU EP		Addition to lower extremity, thigh/weight bearing, lacer, non-molded	All	N	Purchase
L2540	NU EP		Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model	All	N	Purchase
L2550	NU EP		Addition to lower extremity, thigh/weight bearing, high roll cuff	All	N	Purchase
L2570	NU EP		Addition to lower extremity, pelvic control, hip joint, Clevis type two position joint, each	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2580	NU EP		Addition to lower extremity, pelvic control, pelvic sling	All	N	Purchase
L2600	NU EP		Addition to lower extremity, pelvic control, hip joint, Clevis type, or thrust bearing, free, each	All	N	Purchase
L2610	NU EP		Addition to lower extremity, pelvic control, hip joint, Clevis or thrust bearing, lock, each	All	N	Purchase
L2620	NU EP		Addition to lower extremity, pelvic control, hip joint, heavy-duty, each	All	N	Purchase
L2622	NU EP		Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each	All	N	Purchase
L2624	NU EP		Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each	All	N	Purchase
L2627	NU EP		Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables	All	N	Purchase
L2628	NU EP		Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables	All	N	Purchase
L2630	NU EP		Addition to lower extremity, pelvic control, band and belt unilateral	All	N	Purchase
L2640	NU EP		Addition to lower extremity, pelvic control, band and belt bilateral	All	N	Purchase
L2650	NU EP		Addition to lower extremity, pelvic and thoracic control, gluteal pad, each	All	N	Purchase
L2660	NU EP		Addition to lower extremity, thoracic control, thoracic band	All	N	Purchase
L2670	NU EP		Addition to lower extremity, thoracic control, paraspinal uprights	All	N	Purchase
L2680	NU EP		Addition to lower extremity, thoracic control, lateral support uprights	All	N	Purchase
L2750	NU EP		Addition to lower extremity orthosis, plating chrome or nickel, per bar	All	N	Purchase
L2755	NU EP		⁂(Carbon composite ankles; addition to AFO) Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2760	NU EP		Addition to lower extremity orthosis, extension, per extension, per bar (for linear adjustment for growth)	All	N	Purchase
L2780	NU EP		Addition to lower extremity orthosis, non-corrosive finish, per bar	All	N	Purchase
L2785	NU EP		Addition to lower extremity orthosis, drop lock retainer, each	All	N	Purchase
L2795	NU EP		Addition to lower extremity orthosis, knee control, full kneecap	All	N	Purchase
L2800	NU EP		Addition to lower extremity orthosis, knee control, kneecap, medial or lateral pull, for use with custom fabricated orthosis only	All	N	Purchase
L2810	NU EP		Addition to lower extremity orthosis, knee control, condylar pad	All	N	Purchase
L2810	EP		**(Custom night "A" frame KAFO, torsion control, bilateral night "A" frame) Addition to lower extremity orthosis, knee control, condylar pad	U21	N/A	Purchase
L2820	NU EP		Addition to lower extremity orthosis, soft interface for molded plastic, below knee section	All	N	Purchase
L2830	NU EP		Addition to lower extremity orthosis, soft interface for molded plastic, above knee section	All	N	Purchase
L2840	NU EP		Addition to lower extremity orthosis, tibial length sock, fracture or equal, each	All	N	Purchase
L2850	NU EP		Addition to lower extremity orthosis, femoral length sock, fracture or equal, each	All	N	Purchase
L2861	EP		Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	U21	Y	Manually Priced
L2999	EP		Lower extremity orthoses, NOS	All	N	Manually Priced
L2999	NU EP		**(Unlisted prosthetic devices or orthotic appliances; the manufacturer's invoice must be attached to all claims.) Lower extremity orthoses, NOS	All	Y	Manually Priced
L3000	NU EP		Foot insert, removable, molded to patient model, UCB type, Berkeley shell, each	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3002	NU EP		Foot insert, removable, molded to patient model, Plastazote or equal, each	All	N	Manually Priced
L3010	NU EP		Foot insert, removable, molded to patient model, longitudinal arch support, each	All	N	Purchase
L3020	NU EP		Foot insert, removable, molded to patient model, longitudinal/metatarsal support, each	All	N	Purchase
L3030	NU EP		Foot insert, removable, formed to patient foot, each	All	N	Purchase
L3040	NU EP		Foot, arch support, removable, premolded, longitudinal, each	All	N	Purchase
L3050	NU EP		Foot, arch support, removable, premolded, metatarsal, each	All	N	Purchase
L3060	NU EP		Foot, arch support, removable, premolded, longitudinal/metatarsal, each	All	N	Purchase
L3070	NU EP		Foot, arch support, non-removable, attached to shoe, longitudinal, each	All	N	Purchase
L3080	NU EP		Foot, arch support, non-removable, attached to shoe, metatarsal, each	All	N	Purchase
L3090	NU EP		Foot, arch support, non-removable, attached to shoe, longitudinal/metatarsal, each	All	N	Purchase
L3100	NU EP		Hallus -valgus night dynamic splint	All	N	Purchase
L3140	NU EP	UB	⁂(Bebox foot orthosis club foot abduction orthosis) Foot, abduction rotation bar, including shoes	All	Y	Purchase
L3140	NU		⁂(Don Joy knee orthosis) Foot, abduction rotation bar, including shoes	21+	Y	Purchase
L3150	NU EP		Foot, abduction rotation bar, without shoes	All	N	Purchase
L3150	EP	UB	⁂(Custom night "A" frame KAFO, torsion control, bilateral night "A" frame) Foot, abduction rotation bar, without shoes	U21	N	Purchase
L3170	NU EP		Foot, plastic, silicone or equal, heel stabilizer, each	All	N	Purchase
L3202	EP		Orthopedic shoe, Oxford with supinator or pronator, child	U21	N/A	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3204	NU EP		**(Straight last hightop shoe, each, size 2-8) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3204	NU EP	U1	**(Straight last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3204	NU EP	U1	**(Regular last hightop shoe, each, size 3-6) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3204	NU EP	U1	**(Regular last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3204	NU EP	U1	**(Reverse last closed toe) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3204	NU		**(Orthopedic shoe, hightop, normal last, each, size 3-8) Orthopedic shoe, hightop with supinator or pronator, infant	21+	N	Purchase
L3204	NU EP	U1	**(Orthopedic shoe, hightop, normal last, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, infant	All	N	Purchase
L3206	NU EP		**(Straight last hightop shoe, each, size 2-8) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3206	NU EP	U1	**(Straight last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3206	NU EP	U1	**(Regular last hightop shoe, each, size 3-6) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3206	NU EP	U1	**(Regular last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3206	NU EP	U1	**(Reverse last closed toe) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3206	NU		**(Orthopedic shoe, hightop, normal last, each, size 3-8) Orthopedic shoe, hightop with supinator or pronator, child	21+	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3206	NU EP	U1	**(Orthopedic shoe, hightop, normal last, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, child	All	N	Purchase
L3207	NU EP		**(Straight last hightop shoe, each, size 2-8) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU EP	U1	**(Straight last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU EP	U1	**(Regular last hightop shoe, each, size 3-6) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU EP	U1	**(Regular last hightop shoe, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU EP	U1	**(Reverse last closed toe) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU		**(Orthopedic shoe, hightop, normal last, each, size 3-8) Orthopedic shoe, hightop with supinator or pronator, junior	21+	N	Purchase
L3207	NU EP	U1	**(Orthopedic shoe, hightop, normal last, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3207	NU EP		**(Orthopedic shoe, hightop, normal last, each, size 8½-12) Orthopedic shoe, hightop with supinator or pronator, junior	All	N	Purchase
L3208	EP		Surgical boot, each, infant	U21	N/A	Purchase
L3209	EP		Surgical boot, each, child	U21	N/A	Purchase
L3211	EP		Surgical boot, each, junior	U21	N/A	Purchase
L3215	NU EP		Orthopedic footwear, woman's shoes, oxford, each	All	Y	Purchase
L3216	NU EP		Orthopedic footwear, woman's shoes, depth inlay, each	All	Y	Purchase
L3217	NU EP		**(Straight last hightop shoe, each, size 2-8) Orthopedic footwear, woman's shoes, hightop, depth inlay, each	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3217	NU EP	U1 U1	**(Straight last hightop shoe, each, size 8½-12) Orthopedic footwear, woman's shoes, hightop, depth inlay, each	All	N	Purchase
L3217	NU EP	U1	**(Regular last hightop shoe, each, size 3-6) Orthopedic footwear, woman's shoes, hightop, depth inlay, each	All	N	Purchase
L3217	NU EP	U1	**(Regular last hightop shoe, each, size 8½-12) Orthopedic footwear, woman's shoes, hightop, depth inlay, each	All	N	Purchase
L3217	NU EP	U1	**(Reverse last closed toe) Orthopedic footwear, woman's shoes, hightop, depth inlay, each	All	N	Purchase
L3219	NU EP		Orthopedic footwear, man's shoes, oxford, each	All	Y	Purchase
L3221	NU EP		Orthopedic footwear, man's shoes, depth inlay, each	All	Y	Purchase
L3222	NU EP		**(Straight last hightop shoe, each, size 2-8) Orthopedic footwear, man's shoes, hightop, depth inlay, each	All	N	Purchase
L3222	NU EP	U1 U1	**(Straight last hightop shoe, each, size 8½-12) Orthopedic footwear, man's shoes, hightop, depth inlay, each	All	N	Purchase
L3222	NU EP	U1 U1	**(Regular last hightop shoe, each, size 3-6) Orthopedic footwear, man's shoes, high-top, depth inlay, each	All	N	Purchase
L3222	NU EP	U1 U1	**(Regular last hightop shoe, each, size 8½-12) Orthopedic footwear, man's shoes, hightop, depth inlay, each	All	N	Purchase
L3222	NU EP	U1 U1	**(Reverse last closed toe) Orthopedic footwear, man's shoes, hightop, depth inlay, each	All	N	Purchase
L3224	NU		Orthopedic footwear, woman's shoe, Oxford, used as an integral part of a brace (orthosis)	21+	N	Purchase
L3225	NU		Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)	21+	N	Purchase
L3230	NU EP		Orthopedic footwear, custom shoes, depth inlay, each	All	Y	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3250	NU EP		Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each	All	Y	Purchase
L3253	NU EP		Foot, molded shoe Plastazote (or similar), custom fitted, each	All	Y	Purchase
L3257	NU EP		Orthopedic footwear, additional charge for split size	All	Y	Purchase
L3260	NU EP		Surgical boot/shoe, each	All	N	Manually Priced Purchase
L3265	NU EP		Plastazote sandal, each	All	N	Purchase
L3310	NU EP		Lift, elevation, heel and sole, neoprene, per in.	All	N	Purchase
L3332	NU EP		Lift, elevation, inside shoe, tapered, up to one-half in.	All	N	Purchase
L3334	NU EP		Lift, elevation, heel, per inch	All	N	Purchase
L3350	NU EP		Heel wedge	All	N	Purchase
L3360	NU EP		Sole wedge, outside sole	All	N	Purchase
L3370	NU EP		Sole wedge, between sole	All	N	Purchase
L3400	NU EP		Metatarsal bar wedge, rocker	All	N	Purchase
L3420	NU EP		Full sole and heel wedge, between sole	All	N	Purchase
L3450	NU EP		Heel, SACH cushion type	All	N	Purchase
L3455	NU EP		Heel, new leather, standard	All	N	Purchase
L3465	NU EP		Heel, Thomas with wedge	All	N	Purchase
L3540	NU EP		Orthopedic shoe addition, sole, full	All	N	Purchase
L3580	NU EP		Orthopedic shoe addition, convert instep to Velcro closure	All	N	Purchase
L3590	NU EP		Orthopedic shoe addition, convert firm shoe counter to soft counter	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3600	NU EP		Transfer of an orthosis from one shoe to another, caliper plate, existing	All	N	Purchase
L3620	NU EP		Transfer of an orthosis from one shoe to another, solid stirrup, existing	All	N	Purchase
L3630	NU EP		Transfer of an orthosis from one shoe to another, solid stirrup, new	All	N	Purchase
L3649	NU EP	U1 U1	**(Unlisted prosthetic devices or orthotic appliances; the manufacturer's invoice must be attached to all claims.) Orthopedic shoe, modification, addition or transfer, NOS	All	Y	Manually Priced
L3649	EP		**(Orthopedic footwear, wooden sole shoe, each) Orthopedic shoe, modification, addition or transfer, NOS	U21	N/A	Purchase
L3649	NU		**(Orthopedic footwear, wooden sole shoe, each) Orthopedic shoe, modification, addition or transfer, NOS	All	N	Manually Priced
L3650	NU EP		SO, figure of eight design abduction re-strainer prefabricated, includes fitting and adjustment	All	N	Purchase
L3660	NU EP		SO, figure of eight design, abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment	All	N	Purchase
L3670	NU EP		SO, acromio/clavicular (canvas and webbing type) prefabricated, includes fitting and adjustment	All	N	Purchase
L3674	NU EP		Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment	All	N	Purchase
L3675	NU		SO, vest type abduction restrainer, canvas webbing type, or equal, prefabricated, includes fitting and adjustment	21+	N	Purchase
L3710	NU EP		EO, elastic with metal joints, prefabricated, includes fitting and adjustment	All	N	Purchase
L3720	NU EP		EO, double upright with forearm/arm cuffs, free motion, custom fabricated	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3730	NU EP		EO, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated	All	Y	Purchase
L3740	NU EP		EO, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated	All	Y	Purchase
L3807	NU EP		WHFO, without joint(s), prefabricated, includes fitting and adjustments, any type	All	N	Purchase
L3808	NU EP		Wrist hand finger orthotic (WHFO), rigid without joints, may include soft interface material; straps, custom fabricated, includes fitting and adjustment	All	N	Purchase
L3891	EP		Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each	U21	Y	Manually Priced
L3900	NU EP		WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated	All	Y	Purchase
L3901	NU EP		WHFO, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated	All	Y	Purchase
L3904	NU EP		WHFO, external powered, electric, custom fabricated	All	Y	Purchase
L3906**	NU EP		Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment	All	N	Purchase
L3908	NU EP		WHFO, wrist extension control cock-up, nonmolded, prefabricated, includes fitting and adjustment	All	N	Purchase
L3912	NU EP		HFO, flexion glove with elastic finger control, prefabricated, includes fitting and adjustment	All	N	Purchase
L3915*	NU EP		Wrist, hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment	All	N	Manually Priced

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3925	NU EP		FO, proximal interphalangeal (PIP)/distal interphalangeal (DIP), nontorsion joint/spring, extension/flexion, may include soft interface material, prefabricated, includes fitting and adjustment	All	N	Purchase
L3929	NU EP		HFO, includes one or more nontorsion joint(s) turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	All	N	Purchase
L3931	NU EP		WHFO, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment	All	N	Purchase
L3956	NU		Addition of joint to upper extremity orthosis, any material; per joint	21+	N	Manually Priced
L3960	NU EP		SEWHO, abduction, positioning, airplane design, prefabricated, includes fitting and adjustment	All	Y	Purchase
L3962	NU EP		SEWHO, abduction positioning, Erb's palsy design, prefabricated, includes fitting and adjustment	All	N	Purchase
L3964	NU EP		SEO, mobile arm supports attached to wheelchair, balanced, adjustable, prefabricated, includes fitting and adjustment	All	N	Purchase
L3965	NU EP		SEO mobile arm support attached to wheelchair, balanced, adjustable Rancho type, prefabricated, includes fitting and adjustment	All	Y	Purchase
L3966	NU EP		SEO, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, includes fitting and adjustment	All	Y	Purchase
L3969	NU EP		SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, includes fitting and adjustment	All	N	Purchase
L3980	NU EP		Upper extremity fracture orthosis, humeral, prefabricated, includes fitting and adjustment	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L3982	NU EP		Upper extremity fracture orthosis, radius/ulnar prefabricated, includes fitting and adjustment	All	N	Purchase
L3984	NU EP		Upper extremity fracture orthosis, wrist, prefabricated, includes fitting and adjustment	All	N	Purchase
L3995	NU EP		Addition to upper extremity orthosis sock, fracture or equal, each	All	N	Purchase
L3999	NU EP		**(The manufacturer's invoice must be attached to all claims.) Upper limb orthosis, NOS	All	Y	Manually Priced Manually Priced
L4000	NU EP		Replace girdle for spinal orthosis (CTLSO or SO)	All	Y	Purchase
L4002	NU EP		Replace strap, any orthosis, includes all components, any length, any type	All	N	Manually Priced
L4010	NU EP		Replace trilateral socket brim	All	N	Purchase
L4020	NU EP		Replace quadrilateral socket brim, molded to patient model	All	N	Purchase
L4030	NU EP		Replace quadrilateral socket brim, custom fitted	All	N	Purchase
L4040	NU EP		Replace molded thigh lacer, for custom fabricated orthosis only	All	N	Purchase
L4045	NU EP		Replace nonmolded thigh lacer, for custom fabricated orthosis only	All	N	Purchase
L4050	NU EP		Replace molded calf lacer, for custom fabricated orthosis only	All	N	Purchase
L4055	NU EP		Replace nonmolded calf lacer, for custom fabricated orthosis only	All	N	Purchase
L4060	NU EP		Replace high roll cuff	All	N	Purchase
L4070	NU EP		Replace proximal and distal upright for KAFO	All	N	Purchase
L4080	NU EP		Replace metal bands KAFO, proximal thigh	All	N	Purchase
L4090	NU EP		**(Custom night A frame KAFO, torsion control, bilateral night "A" frame) Replace metal bands KAFO-AFO, calf or distal thigh	All	N	Purchase
L4100	NU EP		Replace leather cuff KAFO, proximal thigh	All	N	Purchase

Orthotic Appliances, All Ages (Section 242.180)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L4110	NU EP		Replace leather cuff KAFO-AFO, calf or distal thigh	All	N	Purchase
L4130	NU EP		Replace pretibial shell	All	N	Purchase
L4205	NU EP		Repair of orthotic device, labor component, per 15 minutes	All	Y	Purchase
L4210	NU EP		Repair of orthotic device, repair or replace minor parts	All	Y	Purchase
L4350	NU EP		Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, includes fitting and adjustment	All	N	Purchase
L4360	NU EP		Walking boot, pneumatic with or without joints, with or without interface material, prefabricated, includes fitting and adjustment	All	N	Purchase
L4370	NU EP		Pneumatic full leg splint, prefabricated, includes fitting and adjustment	All	N	Purchase
L4380	NU EP		Pneumatic knee splint, prefabricated, includes fitting and adjustment	All	N	Purchase
L4392	NU		Replacement soft interface material, static AFO	21+	N	Purchase
L4394	NU		Replace soft interface material, foot drop splint	21+	N	Purchase
L4396	NU		Static ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, pressure reduction, may be used for minimal ambulation, prefabricated, includes fitting and adjustment	21+	N	Purchase
L4398	NU		Foot drop splint, recumbent positioning device, prefabricated, includes fitting and adjustment	21+	N	Purchase
L5999	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; **the manufacturer's invoice must be attached to all claims.**) Lower extremity prosthesis, not otherwise specified	All	Y	Manually Priced Manually Priced
L7499	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; **the manufacturer's invoice must be attached to all claims.**) Upper extremity prosthesis, not otherwise specified	All	Y	Manually Priced Manually Priced

~~Orthotic Appliances, All Ages (Section 242.180)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~All U21 21+~~	~~PA 21+~~	~~Payment Method~~
~~L7510~~	~~NU EP~~	~~UB~~	~~Repair of prosthetic device, hourly rate~~	~~All~~	~~Y~~	~~Purchase~~
~~L7520~~	~~NU EP~~		~~Repair prosthetic device, labor component, per 15 minutes~~	~~All~~	~~Y~~	~~Purchase~~
~~L8499~~	~~NU EP~~		~~⁂(Unlisted Prosthetic Devices or Orthotic Appliances; **the manufacturer's invoice must be attached to all claims.**) Unlisted procedure for miscellaneous prosthetic services~~	~~All~~	~~Y~~	~~Manually Priced~~

242.190 Prosthetic Devices for Beneficiaries of All Ages

~~11-1-17~~10-1-22~~1~~

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for beneficiaries age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for beneficiaries under age 21 and "21+" is shown when the code is payable only for those beneficiaries age 21 and older.

[1] The purchase of this component is limited to one per five-year period for beneficiaries age 21 and over.

* Replacement only

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

NOTE: Procedure codes for prosthetic eyes and information regarding prosthetic eye care is located in the Arkansas Medicaid Visual Care Program Manual.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~Prosthetic Devices, All Ages (Section 242.190)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~All U21 21+~~	~~PA 21+~~	~~Payment Method~~
~~L1499~~	~~NU~~		~~⁂(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Spinal orthosis, not otherwise specified~~	~~All~~	~~Y~~	~~Manually Priced~~
	~~EP~~					~~Manually Priced~~

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L2999	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Lower extremity orthoses, NOS	All	Y	Manually Priced Manually Priced
L3649	NU EP		Orthopedic shoe, modification, addition or transfer, NOS	All	N	Purchase
L3649	NU EP	U1 U1	**(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Orthopedic shoe, modification, addition or transfer, NOS	All	Y	Manually Priced Manually Priced
L3999	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Upper limb orthosis, NOS	All	Y	Manually Priced Manually Priced
L4205	NU EP		**(Orthotics and Prosthetics Repairs) Repair of orthotic device, labor component, per 15 minutes	All	Y	Manually Priced Purchase
L4210	NU EP		**(Orthotics and Prosthetics Repairs) Repair of orthotic device, repair or replace minor parts	All	Y	Manually Priced Purchase
L4386	NU EP		Walking boot, nonpneumatic, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment	All	N	Purchase
L4631	NU EP		Ankle foot orthosis, walking boot type, varus/valgas correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material, includes straps and closures, custom fabricated	All	N	Purchase
L5000	NU EP		Partial foot, shoe insert with longitudinal arch, toe filler	All	N	Purchase
L5010	NU EP		Partial foot, molded socket, ankle height, with toe filler	All	Y	Purchase
L5020	NU EP		Partial foot, molded socket, tibial tubercle height, with toe filler	All	Y	Purchase
L5050	NU EP		Ankle, Symes, molded socket, SACH foot	All	Y	Purchase
L5060	NU EP		Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot	All	Y	Purchase
L5100	NU EP		Below knee, molded socket, shin, SACH foot	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5105	NU EP		Below knee, plastic socket, joints and thigh lacer, SACH foot	All	Y	Purchase
L5150	NU EP		Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot	All	Y	Purchase
L5160	NU EP		Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, SACH foot	All	Y	Purchase
L5200	NU EP		Above knee, molded socket, single axis constant friction knee, shin, SACH foot	All	Y	Purchase
L5210	NU EP		Above knee, short prosthesis, no knee joint ("stubbies"), with foot blocks, no ankle joints, each	All	Y	Purchase
L5220	NU EP		Above knee, short prosthesis, no knee joint ("stubbies"), with articulated ankle/foot, dynamically aligned, each	All	Y	Purchase
L5230	NU EP		Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot	All	Y	Purchase
L5250	NU EP		Hip disarticulation, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot	All	Y	Purchase
L5270	NU EP		Hip disarticulation, tilt table type, molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot	All	Y	Purchase
L5280	NU EP		Hemipelvectomy, Canadian type, molded socket, hip joint, single axis constant friction knee, shin, SACH foot	All	Y	Purchase
L5301	NU EP		Below knee, molded socket, shin, SACH foot, endoskeletal system	All	Y	Purchase
L5312	NU EP		Knee disarticulation (or through knee), molded socket, single axis knee, pylon, SACH foot, endoskeletal system	All	Y	Purchase
L5321	NU EP		Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee	All	Y	Purchase
L5331	NU EP		Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	All	Y	Purchase
L5341	NU EP		Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee, SACH foot	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5400	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee	All	N	Purchase
L5410	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment	All	N	Purchase
L5420	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, and one cast change "AK" or knee disarticulation	All	Y	Purchase
L5430	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension , "AK" or knee disarticulation, each additional cast change and realignment	All	N	Purchase
L5450	NU EP		Immediate post-surgical or early fitting, application of nonweight bearing rigid dressing, below knee	All	N	Purchase
L5460	NU EP		Immediate post-surgical or early fitting, application of nonweight bearing rigid dressing, above knee	All	N	Purchase
L5500	NU EP		Initial, below knee ("PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed	All	N	Purchase
L5505	NU EP		Initial, above knee-knee disarticulation (ischial level socket, non-alignable system, pylon, no cover, SACH foot plaster socket, direct formed	All	Y	Purchase
L5510	NU EP		Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model	All	Y	Purchase
L5520	NU EP		Preparatory, below knee "PTB" type socket, non-alignable pylon, no cover, SACH foot, thermoplastic or equal, direct formed	All	Y	Purchase
L5530	NU EP		Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5535	NU EP		Preparatory, below knee "PTB" type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket	All	Y	Purchase
L5540	NU EP		Preparatory, below knee "PTB" type socket, non alignable, pylon, no cover, SACH foot, laminated socket, molded to model	All	Y	Purchase
L5560	NU EP		Preparatory, above knee-knee disarticulation ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model	All	Y	Purchase
L5570	NU EP		Preparatory, above knee-knee disarticulation ischial level socket, non-alignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed	All	Y	Purchase
L5580	NU EP		Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model	All	Y	Purchase
L5585	NU EP		Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket	All	Y	Purchase
L5590	NU EP		Preparatory, above knee-knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model	All	Y	Purchase
L5595	NU EP		Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model	All	Y	Purchase
L5600	NU EP		Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model	All	Y	Purchase
L5610	NU EP		Addition to lower extremity, endoskeletal system, above knee, hydracadence system	All	Y	Purchase
L5611	NU EP		Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4-bar linkage, with friction swing phase control	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5613	NU EP		Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4-bar linkage, with hydraulic swing phase control	All	Y	Purchase
L5614	NU		Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4-bar linkage, with pneumatic swing phase control	21+	Y	Purchase
L5616	NU EP		Addition to lower extremity, endoskeletal system above knee, universal multiplex system, friction swing phase control	All	Y	Purchase
L5617	NU		Addition to lower extremity, quick change self-aligning unit, above or below knee, each	21+	Y	Purchase
L5618	NU EP		Addition to lower extremity, test socket, Symes	All	N	Purchase
L5620	NU EP		Addition to lower extremity, test socket, below knee	All	N	Purchase
L5622	NU EP		Addition to lower extremity, test socket, knee disarticulation	All	N	Purchase
L5624	NU EP		Addition to lower extremity, test socket, above knee	All	N	Purchase
L5626	NU EP		Addition to lower extremity, test socket, hip disarticulation	All	N	Purchase
L5628	NU EP		Addition to lower extremity, test socket, hemipelvectomy	All	N	Purchase
L5629	NU EP		Addition to lower extremity, below knee, acrylic socket	All	N	Purchase
L5630	NU EP		Addition to lower extremity, Symes type, expandable wall socket	All	N	Purchase
L5631	NU EP		Addition to lower extremity, above knee or knee disarticulation, acrylic socket	All	N	Purchase
L5632	NU EP		Addition to lower extremity, Symes type, "PTB" brim design socket	All	N	Purchase
L5634	NU EP		Addition to lower extremity, Symes type posterior opening (Canadian) socket	All	N	Purchase
L5636	NU EP		Additions to lower extremity, Symes type, medial opening socket	All	N	Purchase
L5637	NU EP		Addition to lower extremity, below knee, total contact	All	N	Purchase
L5638	NU EP		Addition to lower extremity, below knee, leather socket	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5639	NU EP		Addition to lower extremity, below knee, wood socket	All	N	Purchase
L5640	NU EP		Addition to lower extremity, knee disarticulation, leather socket	All	N	Purchase
L5642	NU EP		Addition to lower extremity, above knee, leather socket	All	N	Purchase
L5643	NU EP		Addition to lower extremity, hip disarticulation, flexible inner socket, external frame	All	Y	Purchase
L5644	NU EP		Addition to lower extremity, above knee, wood socket	All	N	Purchase
L5645	NU EP		Addition to lower extremity, below knee, flexible inner socket, external frame	All	N	Purchase
L5646	NU EP		Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket	All	N	Purchase
L5647	NU EP		Addition to lower extremity, below knee suction socket	All	N	Purchase
L5648	NU EP		Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket	All	N	Purchase
L5649	NU EP		Addition to lower extremity, ischial containment/narrow M-L socket	All	Y	Purchase
L5650	NU EP		Addition to lower extremity, total contact, above knee or knee disarticulation socket	All	N	Purchase
L5651	NU EP		Addition to lower extremity, above knee, flexible inner socket, external frame	All	N	Purchase
L5652	NU EP		Addition to lower extremity, suction suspension, above knee or knee disarticulation, socket	All	N	Purchase
L5653	NU EP		Addition to lower extremity, knee disarticulation, expandable wall socket	All	N	Purchase
L5654	NU EP		Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)	All	N	Purchase
L5655	NU EP		Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	All	N	Purchase
L5656	NU EP		Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)	All	N	Purchase
L5658	NU EP		Addition to lower extremity, socket insert, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5661	NU EP		Addition to lower extremity, socket insert, multi-durometer Symes	All	N	Purchase
L5665	EP		Addition to lower extremity, socket insert, multi-durometer, below knee	U21	N/A	Purchase
L5666	NU EP		Additions to lower extremity, below knee, cuff suspension	All	N	Purchase
L5668	NU EP		Addition to lower extremity, below knee, molded distal cushion	All	N	Purchase
L5670	NU EP		Addition to lower extremity, below knee, molded supracondylar suspension ("PTS" or similar)	All	N	Purchase
L5671	NU EP		Addition to lower extremity, below knee/above knee, suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert	All	N	Purchase
L5672	NU EP		Addition to lower extremity, below knee, removable medial brim suspension	All	N	Purchase
L5673	NU EP		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism	All	N	Purchase
L5676	NU EP		Addition to lower extremity, below knee, knee joints, single axis, pair	All	N	Purchase
L5677	NU EP		Addition to lower extremity, below knee, knee joints, polycentric, pair	All	N	Purchase
L5678	NU EP		Addition to lower extremity, below knee, joint covers, pair	All	N	Purchase
L5679	NU EP		Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism	All	N	Purchase
L5680	NU EP		Addition to lower extremity, below knee, thigh lacer, nonmolded	All	N	Purchase
L5681	NU EP		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only	All	N	Purchase
L5682	NU EP		Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5683	EP		Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only	U21	N	Purchase
L5684	NU EP		Addition to lower extremity, below knee, fork strap	All	N	Purchase
L5685	NU EP		Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each	All	N	Manually Priced
L5686	NU EP		Addition to lower extremity, below knee, back check (extension control)	All	N	Purchase
L5688	NU EP		Addition to lower extremity, below knee, waist belt, webbing	All	N	Purchase
L5690	NU EP		Addition to lower extremity, below knee, waist belt, padded and lined	All	N	Purchase
L5692	NU EP		Addition to lower extremity, above knee, pelvic control belt, light	All	N	Purchase
L5694	NU EP		Addition to lower extremity, above knee, pelvic control belt, padded and lined	All	N	Purchase
L5695	NU EP		Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each	All	N	Purchase
L5696	NU EP		Addition to lower extremity, above knee or knee disarticulation, pelvic joint	All	N	Purchase
L5697	NU EP		Addition to lower extremity, above knee or knee disarticulation, pelvic band	All	N	Purchase
L5698	NU EP		Addition to lower extremity, above knee or knee disarticulation, Silesian bandage	All	N	Purchase
L5699	NU EP		All lower extremity prosthesis, shoulder harness	All	N	Purchase
L5700	NU		Replacement, socket, below knee, molded to patient model	21+	Y	Purchase
L5701	NU		Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model	21+	Y	Purchase
L5702	NU		Replacement, socket, hip disarticulation, including hip joint, molded to patient model	21+	Y	Purchase
L5704	NU EP		Custom shaped protective cover, below knee	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5705	NU		Custom shaped protective cover, above knee	21+	N	Purchase
L5706	NU		Custom shaped protective cover, knee disarticulation	21+	N	Purchase
L5707	NU		Custom shaped protective cover, hip disarticulation	21+	N	Purchase
L5710	NU EP		Addition, exoskeletal knee-shin system, single axis, manual lock	All	N	Purchase
L5711	NU EP		Addition exoskeletal knee-shin system, single axis, manual lock, ultra-light material	All	N	Purchase
L5712	NU EP		Addition exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	All	N	Purchase
L5714	NU EP		Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control	All	N	Purchase
L5716	NU EP		Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock	All	N	Purchase
L5718	NU EP		Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control	All	N	Purchase
L5722	NU EP		Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	All	N	Purchase
L5724	NU EP		Addition, exoskeletal knee-shin system, single axis, fluid swing phase control	All	Y	Purchase
L5726	NU EP		Addition, exoskeletal knee-shin system, single axis, external joints, fluid swing phase control	All	Y	Purchase
L5728	NU EP		Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control	All	Y	Purchase
L5780	NU EP		Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control	All	N	Purchase
L5785	NU EP		Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase
L5790	NU EP		Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5795	NU EP		Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase
L5810	NU EP		Addition, endoskeletal knee-shin system, single axis, manual lock	All	N	Purchase
L5811	NU EP		Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material	All	N	Purchase
L5812	NU EP		Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)	All	N	Purchase
L5814	NU		Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock	21+	Y	Purchase
L5816	NU EP		Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock	All	N	Purchase
L5818	NU EP		Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control	All	N	Purchase
L5822	NU EP		Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control	All	Y	Purchase
L5824	NU EP		Addition, endoskeletal knee-shin system, single axis, fluid swing phase control	All	Y	Purchase
L5826	NU		Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control with miniature high activity frame	21+	Y	Purchase
L5828	NU EP		Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control	All	Y	Purchase
L5830	NU EP		Addition, endoskeletal knee-shin system, single axis, pneumatic/swing phase control	All	Y	Purchase
L5840	NU		Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control	21+	N	Purchase
L5845	NU		Addition, endoskeletal knee-shin system, stance flexion feature, adjustable	21+	Y	Purchase
L5850	NU EP		Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist	All	N	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5855	NU		Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist	21+	N	Purchase
L5910	NU EP		Addition, endoskeletal system, below knee, alignable system	All	N	Purchase
L5920	NU EP		Addition, endoskeletal system, above knee or hip disarticulation, alignable system	All	N	Purchase
L5925	NU		Addition, endoskeletal system, above knee, knee disarticulation, manual lock	21+	N	Purchase
L5930	NU		Addition, endoskeletal system, high activity knee control frame	21+	Y	Purchase
L5940	NU EP		Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase
L5950	NU EP		Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase
L5960	NU EP		Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)	All	N	Purchase
L5961	NU EP		Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion, and/or extension control	All	N	Manually Priced
L5962	NU EP		Addition, endoskeletal system, below knee, flexible protective outer surface covering system	All	N	Purchase
L5964	NU		Addition, endoskeletal system, above knee, flexible protective outer surface covering system	21+	N	Purchase
L5966	NU		Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system	21+	N	Purchase
L5968	NU		Addition to lower limb prostheses, multiaxial ankle with swing phase active dorsiflexion feature	21+	Y	Purchase
L5970	NU EP		All lower extremity prostheses, foot, external keel, SACH foot	All	N	Purchase
L5972	NU EP		All lower extremity prostheses, flexible keel foot (SAFE, STEN, Bock Dynamic or equal)	All	N	Purchase
L5974	NU EP		All lower extremity prostheses, foot, single axis ankle/foot	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L5975	NU		All lower extremity prosthesis, combination single axis ankle and flexible keel foot	21+	N	Purchase
L5976	NU EP		All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)	All	N	Purchase
L5978	NU EP		All lower extremity prostheses, foot, multiaxial ankle/foot	All	N	Purchase
L5979	NU EP		All lower extremity prostheses, multi-axial ankle, dynamic response foot, one piece system	All	Y	Purchase
L5980	NU EP		All lower extremity prostheses, flex-foot system	All	Y	Purchase
L5981	NU EP		All lower extremity prostheses, flex-walk system or equal	All	Y	Purchase
L5982	NU EP		All exoskeletal lower extremity prostheses, axial rotation unit	All	N	Purchase
L5984	NU EP		All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability	All	N	Purchase
L5985	NU		All endoskeletal lower extremity prostheses, dynamic prosthetic pylon	21+	N	Purchase
L5986	NU EP		All lower extremity prostheses, multi-axial rotation unit ("MCP" or equal)	All	N	Purchase
L5987	NU		All lower extremity prostheses, shank foot system with vertical loading pylon	21+	Y	Purchase
L5988	NU		Addition to lower limb prosthesis, vertical shock reducing pylon feature	21+	Y	Purchase
L5999	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Lower extremity prosthesis, not otherwise specified	All	Y	Manually Priced Manually Priced
L6000	NU EP		Partial hand, Robin-Aids, thumb remaining (or equal)	All	N	Purchase
L6010	NU EP		Partial hand, Robin-Aids, little and/or ring finger remaining (or equal)	All	N	Purchase
L6020	NU EP		Partial hand, Robin-Aids, no finger remaining (or equal)	All	N	Purchase
L6050	NU EP		Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6055	NU EP		Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad	All	Y	Purchase
L6100	NU EP		Below elbow, molded socket, flexible elbow hinge, triceps pad	All	Y	Purchase
L6110	NU EP		Below elbow, molded socket (Muenster or Northwestern suspension types)	All	Y	Purchase
L6120	NU EP		Below elbow, molded double wall split socket, step-up hinges, half cuff	All	Y	Purchase
L6130	NU EP		Below elbow, molded double wall split socket, stump activated locking hinge, half cuff	All	Y	Purchase
L6200	NU EP		Elbow disarticulation, molded socket, outside locking hinge, forearm	All	Y	Purchase
L6205	NU EP		Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm	All	Y	Purchase
L6250	NU EP		Above elbow, molded double wall socket, internal locking elbow, forearm	All	Y	Purchase
L6300	NU EP		Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	All	Y	Purchase
L6310	NU EP		Shoulder disarticulation, passive restoration (complete prosthesis)	All	Y	Purchase
L6320	NU EP		Shoulder disarticulation, passive restoration (shoulder cap only)	All	Y	Purchase
L6350	NU EP		Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm	All	Y	Purchase
L6360	NU EP		Interscapular thoracic, passive restoration (complete prosthesis)	All	Y	Purchase
L6370	NU EP		Interscapular thoracic, passive restoration (shoulder cap only)	All	Y	Purchase
L6380	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6382	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow	All	N	Purchase
L6384	NU EP		Immediate post-surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic	All	Y	Purchase
L6386	NU EP		Immediate post-surgical or early fitting, each additional cast change and realignment	All	N	Purchase
L6388	NU EP		Immediate post-surgical or early fitting, application of rigid dressing only	All	N	Purchase
L6400	NU EP		Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	All	Y	Purchase
L6450	NU EP		Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	All	Y	Purchase
L6500	NU EP		Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping	All	Y	Purchase
L6550	NU EP		Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping	All	Y	Purchase
L6570	NU EP		Interscapular thoracic, molded socket, endoskeletal system including soft prosthetic tissue shaping	All	Y	Purchase
L6580	NU EP		Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, “USMC” or equal pylon, no cover, molded to patient model	All	Y	Purchase
L6582	NU EP		Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, Bowden cable control, “USMC” or equal pylon, no cover, direct formed	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6584	NU EP		Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model	All	Y	Purchase
L6586	NU EP		Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, "USMC" or equal pylon, no cover, direct formed	All	Y	Purchase
L6588	NU EP		Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, molded to patient model	All	Y	Purchase
L6590	NU EP		Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, "USMC" or equal pylon, no cover, direct formed	All	Y	Purchase
L6600	NU EP		Upper extremity additions, polycentric hinge, pair	All	N	Purchase
L6605	NU EP		Upper extremity additions, single pivot hinge, pair	All	N	Purchase
L6610	NU EP		Upper extremity additions, flexible metal hinge, pair	All	N	Purchase
L6615	NU EP		Upper extremity addition, disconnect locking wrist unit	All	N	Purchase
L6616	NU EP		Upper extremity addition, additional disconnect insert for locking wrist unit, each	All	N	Purchase
L6620	NU EP		Upper extremity addition, flexion/extension wrist unit, with or without friction	All	N	Purchase
L6623	NU EP		Upper extremity addition, spring assisted rotational wrist unit with latch release	All	N	Purchase
L6624	NU EP		Upper extremity addition, flexion/extension and rotation wrist unit	All	Y	Purchase
L6625	NU EP		Upper extremity addition, rotation wrist unit with cable lock	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6628	NU EP		Upper extremity addition, quick disconnect hook adapter, Otto Bock or equal	All	N	Purchase
L6629	NU EP		Upper extremity addition, quick disconnect lamination collar with coupling piece, Otto Bock or equal	All	N	Purchase
L6630	NU EP		Upper extremity addition, stainless steel, any wrist	All	N	Purchase
L6632	NU EP		Upper extremity addition, latex suspension sleeve, each	All	N	Purchase
L6635	NU EP		Upper extremity additions, lift assist for elbow	All	N	Purchase
L6637	NU EP		Upper extremity addition, nudge control elbow lock	All	N	Purchase
L6640	NU EP		Upper extremity additions, shoulder abduction joint, pair	All	N	Purchase
L6641	NU EP		Upper extremity addition, excursion amplifier, pulley type	All	N	Purchase
L6642	NU EP		Upper extremity addition, excursion amplifier, lever type	All	N	Purchase
L6645	NU EP		Upper extremity addition, shoulder flexion-abduction joint, each	All	N	Purchase
L6650	NU EP		Upper extremity addition, shoulder universal joint, each	All	N	Purchase
L6655	NU EP		Upper extremity addition, standard control cable, extra	All	N	Purchase
L6660	NU EP		Upper extremity addition, heavy-duty control cable	All	N	Purchase
L6665	NU EP		Upper extremity addition, Teflon, or equal, cable lining	All	N	Purchase
L6670	NU EP		Upper extremity addition, hook to hand cable adapter	All	N	Purchase
L6672	NU EP		Upper extremity addition, harness, chest or shoulder, saddle type	All	N	Purchase
L6675	NU EP		Upper extremity addition, harness, (e.g., figure of eight type), single cable design	All	N	Purchase
L6676	NU EP		Upper extremity additions, harness, (e.g., figure of eight type), dual cable design	All	N	Purchase
L6680	NU EP		Upper extremity addition, test socket, wrist disarticulation or below elbow	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6682	NU EP		Upper extremity addition, test socket, elbow disarticulation or above elbow	All	N	Purchase
L6684	NU EP		Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic	All	N	Purchase
L6686	NU EP		Upper extremity addition, suction socket	All	N	Purchase
L6687	NU EP		Upper extremity addition, frame type socket, below elbow or wrist disarticulation	All	N	Purchase
L6688	NU EP		Upper extremity addition, frame type socket, above elbow or elbow disarticulation	All	N	Purchase
L6689	NU EP		Upper extremity addition, frame type socket, shoulder disarticulation	All	N	Purchase
L6690	NU EP		Upper extremity addition, frame type socket, interscapular thoracic	All	N	Purchase
L6691	NU EP		Upper extremity addition, removable insert, each	All	N	Purchase
L6692	NU EP		Upper extremity addition, silicone gel insert or equal, each	All	N	Purchase
L6693	NU		Upper extremity addition, locking elbow, forearm counterbalance	21+	Y	Purchase
L6703[1]	NU EP		Terminal device, passive hand/mitt, any material, any size	All	N	Purchase
L6704[1]	NU EP		Terminal device, sport/recreational/work attachment, any material, any size	All	N	Purchase
L6706[1]	NU EP		Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined	All	N	Purchase
L6707[1]	NU EP		Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined	All	N	Purchase
L6708[1]	NU EP		Terminal device, hand, mechanical, voluntary opening, any material, any size	All	N	Purchase
L6709[1]	NU EP		Terminal device, hand, mechanical, voluntary closing, any material, any size	All	N	Purchase
L6711	EP		Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric	U21	Y	Purchase
L6712	EP		Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric	U21	Y	Purchase

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National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6713	EP		Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric	U21	Y	Purchase
L6714	EP		Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric	U21	N/A	Purchase
L6721	NU		Terminal device, hook or hand, heavy-duty, mechanical, voluntary opening, any material, any size, lined or unlined	21+	Y	Purchase
L6722	NU		Terminal device, hook or hand, heavy-duty, mechanical, voluntary closing, any material, any size, lined or unlined	21+	Y	Purchase
L6805	NU EP		Terminal device, modifier wrist flexion unit	All	N	Purchase
L6810	NU EP		Terminal device, pincher tool, Otto Bock or equal	All	N	Purchase
L6880	NU EP		Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination of grasp patterns, includes motor(s)	All	Y	Purchase
L6890	NU EP		Terminal device, gloves for above hands, production glove	All	N	Purchase
L6895	NU EP		Terminal device, glove for above hands, custom glove	All	N	Purchase
L6900	NU EP		Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining	All	N	Purchase
L6905	NU EP		Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining	All	N	Purchase
L6910	NU EP		Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining	All	N	Purchase
L6915	NU EP		Hand restoration (shading and measurements included), replacement glove for above	All	N	Purchase
L6920*	NU EP		Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal, switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6925*	NU EP		Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L6930*	NU EP		Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase
L6935*	NU EP		Below elbow, external power, self-suspended inner socket, removable forearm shell, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L6940*	NU EP		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase
L6945*	NU EP		Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L6950*	NU EP		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase
L6955*	NU EP		Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L6960*	NU EP		Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L6965*	NU EP		Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L6970*	NU EP		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal switch, cables, two batteries and one charger, switch control of terminal device	All	Y	Purchase
L6975*	NU EP		Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, Otto Bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device	All	Y	Purchase
L7007[1]*	NU EP		Electric hand, switch or myoelectric controlled, adult	All	Y	Purchase
L7008[1]*	NU EP		Electric hand, switch or myoelectric, controlled, pediatric	All	Y	Purchase
L7009	NU EP		Electric hook, switch or myoelectric controlled, adult	All	Y	Purchase
L7040*	NU EP		Prehensile actuator, Hosmer or equal, switch controlled	All	Y	Purchase
L7045*	NU EP		Electronic hook, child, Michigan or equal, switch controlled	All	Y	Purchase
L7170*	NU EP		Electronic elbow, Hosmer or equal, switch controlled	All	Y	Purchase
L7180*	NU EP		Electronic elbow, Utah or equal, myoelectronically controlled	All	Y	Purchase
L7185	EP		Electronic elbow, adolescent, Variety Village or equal, switch controlled	U21	N/A	Purchase
L7186	EP		Electronic elbow, child, Variety Village or equal, switch controlled	U21	N/A	Purchase
L7190	EP		Electronic elbow, adolescent, Variety Village or equal, myoelectronically controlled	U21	N/A	Purchase
L7191	EP		Electronic elbow, child, Variety Village or equal, myoelectronically controlled	U21	N/A	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L7260*	NU EP		Electronic wrist rotator, Otto Bock or equal	All	Y	Purchase
L7261*	NU EP		Electronic wrist rotator, for Utah arm	All	Y	Purchase
L7360*	NU EP		Six volt battery, Otto Bock or equal, each	All	N	Purchase
L7362*	NU EP		Battery charger, six volt, Otto Bock or equal	All	N	Purchase
L7364*	NU EP		Twelve volt battery, Utah or equal, each	All	N	Purchase
L7366*	NU EP		Battery charger, twelve volt, Utah or equal	All	N	Purchase
L7499	NU EP		**(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Upper extremity prosthesis, NOS	All	Y	Manually Priced Manually Priced
L7510	NU EP	 UB	**(Orthotics and Prosthetics Repairs) Repair of prosthetic device, repair or replace minor parts	All	Y	Manually Priced Purchase
L7510	NU EP		**(Twister cables - repair/replace) Repair of prosthetic device, repair or replace minor parts	All	N	Manually Priced Purchase
L7520	NU EP		**(Orthotics and Prosthetics Repairs) Repair prosthetic device, labor component, per 15 minutes	All	Y	Manually Priced Purchase
L8000	NU EP		Breast prosthesis, mastectomy bra	All	N	Purchase
L8010	NU EP		Breast prosthesis, mastectomy sleeve	All	N	Purchase
L8015	NU		External breast prosthesis garment, with mastectomy form, post-mastectomy	21+	N	Purchase
L8020	NU EP		Breast prosthesis, mastectomy form	All	N	Purchase
L8030	NU EP		Breast prosthesis, silicone or equal	All	N	Purchase
L8031	NU EP		Breast prosthesis, silicone or equal, with integral adhesive	All	N	Purchase
L8032	NU EP		Nipple prosthesis, reusable, any type, each	All	N	Purchase
L8300	NU EP		Truss, single with standard pad	All	N	Purchase

Prosthetic Devices, All Ages (Section 242.190)

National Procedure Code	M1	M2	Description	All U21 21+	PA 21+	Payment Method
L8310	NU EP		Truss, double with standard pads	All	N	Purchase
L8320	NU EP		Truss, addition to standard pad, water pad	All	N	Purchase
L8330	NU EP		Truss, addition to standard pad, scrotal pad	All	N	Purchase
L8400	NU EP		Prosthetic sheath, below knee, each	All	N	Purchase
L8410	NU EP		Prosthetic sheath, above knee, each	All	N	Purchase
L8415	NU EP		Prosthetic sheath, upper limb, each	All	N	Purchase
L8417	NU		Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each	21+	N	Purchase
L8420	NU EP		Prosthetic sock, multiple ply, below knee, each	All	N	Purchase
L8430	NU EP		Prosthetic sock, multiple ply, above knee, each	All	N	Purchase
L8435	NU EP		Prosthetic sock, multiple ply upper limb, each	All	N	Purchase
L8440	NU EP		Prosthetic shrinker, below knee, each	All	N	Purchase
L8460	NU EP		Prosthetic shrinker, above knee, each	All	N	Purchase
L8465	NU EP		Prosthetic shrinker, upper limb, each	All	N	Purchase
L8470	NU EP		Prosthetic sock, single ply, fitting below knee, each	All	N	Purchase
L8480	NU EP		Prosthetic sock, single ply fitting, above knee, each	All	N	Purchase
L8485	NU		Prosthetic sock, single ply, fitting, upper limb, each	21+	N	Purchase
L8499	NU EP		⁂(Unlisted Prosthetic Devices or Orthotic Appliances; the manufacturer's invoice must be attached to all claims.) Unlisted procedure for miscellaneous prosthetic services	All	Y	Manually Priced Manually Priced
L8500	NU EP		Artificial larynx, any type	All	N	Purchase
L8501	NU EP		Tracheostomy speaking valve	All	N	Purchase

~~Prosthetic Devices, All Ages (Section 242.190)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~All U21 21+~~	~~PA 21+~~	~~Payment Method~~
~~L8600~~	~~EP~~		~~Implantable breast prosthesis, silicone or equal~~	~~U21~~	~~N~~	~~Manually Priced~~
~~L8605~~	~~NU~~		~~Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, anal canal, 1ml, includes shipping and necessary supplies (covered only for ages 18 and over)~~	~~18+~~	~~N~~	~~Manually Priced~~
~~L8693~~	~~EP~~		~~Auditory osseointegrated device abutment, any length, replacement only~~	~~U21~~	~~Y~~	~~Manually Priced~~
~~V2623~~	~~NU~~		~~Prosthetic eye, plastic, custom~~	~~21+~~	~~N~~	~~Purchase~~
~~V2624~~	~~NU~~		~~Polishing/resurfacing of ocular prosthesis~~	~~21+~~	~~N~~	~~Purchase~~
~~V2625~~	~~NU~~		~~Enlargement of ocular prosthesis~~	~~21+~~	~~N~~	~~Purchase~~
~~V2626~~	~~NU~~		~~Reduction of ocular prosthesis~~	~~21+~~	~~N~~	~~Purchase~~
~~V2628~~	~~NU~~		~~Fabrication and fitting of ocular conformer~~	~~21+~~	~~N~~	~~Purchase~~

242.191 Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult

~~5-22-19~~10-1-~~22~~1

Arkansas Medicaid covers wheelchairs and wheelchair seating systems for individuals ages two through adult.

For any item to be covered by Arkansas Medicaid, the beneficiary must be eligible for a defined Medicaid Aid Category. Coverage is subject to the requirement that the equipment must be medically necessary for the diagnosis or treatment of an illness or injury to improve the functioning of an affected body part, and must meet all other Medicaid statutory and regulatory requirements and established criteria.

The beneficiary's diagnosis must warrant the type of equipment being purchased. Items may not be covered in every instance.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and the provider at the time service is provided and submission of an accurate and complete request. The DME provider is responsible for verifying the eligibility of the beneficiary at the time service is provided.

Specialized wheelchairs and wheelchair seating systems must be ordered by a physician.

For those services that are not included in the Arkansas Medicaid State Plan, (e.g., highly technological wheelchairs and rehab equipment), the PCP must complete form DMS-693, titled Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan. **View or print form DMS-679 and instructions for completion.**

NOTE: If the service or item(s) are specifically included in the Arkansas Medicaid State Plan, the completion of form DMS-693 is not required.

When a request is submitted for a power wheelchair, Power-Operated Vehicle (POV) or specialized manual wheelchair, the following Medicaid requirements must be met:

A. A Prescription & Prior Authorization Request for Medical Equipment form (DMS-679) must be completed and submitted. This form must not be altered by the provider. **View or print form DMS-679 and instructions for completion.**

B. The DMS-679 must be signed and dated by the beneficiary's PCP, APRN or the ordering physician. The signature must be original. Stamp signatures are not acceptable. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

C. Correct Medicaid procedure codes and modifiers must be utilized. Requested items will be denied if correct procedures codes and modifiers are not used.

D. All requests for prior authorization must be legible (felt pens must not be used).

E. Medicaid requires the submission of the original request.

F. Medical documentation from the beneficiary's PCP, APRN or ordering physician which included a detailed face-to-face medical examination must be submitted to establish medical necessity.

G. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. This evaluation will be completed in three parts:

1. Part A—to be completed by the DME provider.
2. Part B—to be completed by the assistive technology practitioner or can be completed by a physical therapist or occupational therapist or seating specialist for Group 1 (one) and Group 2 (two) power wheelchairs with no power options.
3. Part C—to be completed by the beneficiary's PCP, APRN or the ordering physician.
4. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be completed for all specialized wheelchairs except for rental wheelchairs. **View or print form DMS-0843 and instructions for completion.**

H. A manufacturer's order form documenting the suggested retail price for the brand and model wheelchair and accessories and a manufacturer's quote must be submitted with the DMS 679.

I. A DMS-693, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, must be submitted for all pediatric wheelchairs and include detailed PCP or APRN medical documentation that clearly demonstrates medical necessity and clearly identifies the medical condition and the specific equipment that will meet the beneficiary's medical needs. Form DMS-693 and the supporting documentation must be submitted as an attachment to the request for prior authorization. It will then be reviewed for medical necessity. **View or print form DMS-693.**

J. If requirements A through I are not completed correctly, the request could be denied.

K. Arkansas Medicaid requires a Durable Medical Equipment (DME) provider to employ a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified ATP (Assistive Technology Practitioner) who specializes in wheelchair seating. The ATP will provide direct in-person recommendations for evaluation of the beneficiary's wheelchair selection, and is employed by the supplier. This applies for specialized manual wheelchair and power wheelchair in the category of Group 2 (single power option) and above.

The ATP's involvement in the wheelchair selection must be documented. Documentation of the ATP's involvement does not qualify as a face-to-face examination and may not be cosigned by a physician.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Other coding information found in the chart:

[1] **The purchase of this component for beneficiaries age 21 and older is limited to one per five-year period.**

[2] **The purchase of this wheelchair component for beneficiaries under age 21 is limited to one per two-year period.**

* **The purchase of wheelchairs for beneficiaries age 21 and older is limited to one per five-year period.**

** **Bill only for beneficiaries under age 21.**

This procedure code is payable for beneficiaries ages 2 through 20. Prior authorization is required through Utilization Review.

**** **Items listed require prior authorization (PA) when used in combination with other items listed and the total combined value exceeds the $1,000.00 Medicaid maximum allowable reimbursement limit.**

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

Note: W/C or w/c indicates wheelchair.

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~**Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)**~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~
~~E0700~~	~~NU EP~~	~~U1 U1~~	~~Safety equipment, e.g., belt, harness or vest~~	~~N****~~	~~Purchase~~
~~E0700~~	~~NU EP~~	~~U2 U2~~	~~⁂(Travel restraint auto safe harness, E-Z on vest, no known comparable product) Safety equipment, e.g., belt, harness or vest~~	~~N****~~	~~Purchase~~
~~E0950~~	~~NU EP UE~~		~~⁂(Tray for W/C) W/C accessory, tray, each~~	~~Y~~	~~Purchase~~

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0950	NU EP	U2 U2	**(ABS tray, 4 SM 5 LG) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U3 U3	**(W/C Tray, Custom) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U4 U4	**(Tray, customized) W/C accessory, tray, each	N	Purchase
E0950	NU EP	U5 U5	**(Clear upper Ex support system) W/C accessory, tray, each	Y	Purchase
E0950	NU EP	U6 U6	**(Lap Tray Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0950	NU EP UE	U7 U7	**(Removable Hinged Overlay for Tray) W/C accessory, tray, each	Y****	Purchase
E0950	NU EP	U8 U8	**(Lap Tray for Switch Array) Wheelchair accessory, tray, each	Y	Purchase
E0951	NU EP		Heel loop/holder, with or without ankle strap, each	N****	Purchase
E0952	NU EP		Toe loop/holder, each	N****	Purchase
E0955	NU EP		Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each	N	Purchase
E0956	NU EP		**(Trunk supports for any W/C, other than travel, with hardware) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U1 U1	**(Lateral trunk supports, swing away, each) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U2 U2	-**(Med. Chest Panel Support) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0956	NU EP	U3 U3	**(Chest/Thoracic Supports) Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each	N****	Purchase
E0957	NU EP		Wheelchair accessory, medial thigh support, (**-flip-up) any type, including fixed mounting hardware, each	N	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0958	NU EP		Manual W/C accessory, one-arm drive attachment, each	N****	Purchase
E0959	NU EP		**(Amputee adapters for conventional chair, ea.) Manual W/C accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP		**(Amputee axle plate for high performance manual W/C, ea.) Manual wheelchair accessory, adapter for amputee, each	N****	Purchase
E0959	NU EP	U1 U1	Manual W/C accessory, adapter for amputee, each	N	Purchase
E0960	NU EP		W/C accessory, shoulder harness/straps or chest strap including any type mounting hardware	N	Purchase
E0961	NU EP		Manual W/C accessory, wheel lock brake extension (handle), each	N****	Purchase
E0966	NU EP		Manual wheelchair accessory, headrest extension, each	N****	Purchase
E0967	NU EP		**(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U1 U1	**(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U2 U2	**(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U3 U3	**(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0967	NU EP	U4 U4	**(Hand rim, any type) Manual W/C accessory, hand rim w/projections, any type, replacement only, each	N****	Purchase
E0970	NU EP		No. 2 footplates, except for elevating legrest	N****	Purchase
E0971	NU EP		Anti-tipping device W/C	N****	Purchase
E0973	NU EP		W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase
E0973	NU EP	U1 U1	**(Height Adj. Arms, replacement) W/C accessory, adjustable height, detachable armrest, complete assembly, each	N****	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0974	NU EP		Manual wheelchair accessory, anti-rollback device (⁂ grade aids), each	N****	Purchase
E0978	NU EP		Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0978	NU EP	U1 U1	⁂(Belt, safety or chest, w/pad) Wheelchair accessory, positioning belt/safety belt/ pelvic strap, each	N**** N	Purchase
E0978	NU EP	U2 U2	Wheelchair accessory, positioning belt/safety belt/pelvic strap, each	N****	Purchase
E0980	NU EP		⁂(Chest panel, 21-SM 22-LG) Safety vest, wheelchair	N****	Purchase
E0980	NU EP	U1 U1	⁂(Shoulder retractors) Safety vest, W/C	N****	Purchase
E0981	NU EP		W/C accessory, seat upholstery, replacement only, each	N	Purchase
E0982	NU EP		W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0982	NU EP	U1 U1	⁂(Standard back upholstery replacement) W/C accessory, back upholstery, replacement only, each	N****	Purchase
E0990	NU EP		⁂(Elevating foot, leg rest) W/C accessory, elevating leg rest, complete assembly, each	N****	Purchase
E0990	NU EP	U1 U1	⁂(Elevating Leg Rest 90 Degree, 12" - 16" Width) W/C accessory, elevating leg rest, complete assembly, each	N****	Purchase
E0992	NU EP		⁂ (Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U1 U1	⁂Manual w/c accessory, solid seat insert (Large adjustable solid seat w/hardware)	N****	Purchase
E0992	NU EP	U2 U2	⁂(Foam and Plywood Flat Side Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U3 U3	⁂(Foam & Plywood Seat, MPI Like Manual wheelchair accessory, solid seat)	N****	Purchase
E0992	NU EP	U4 U4	⁂(Adjustable solid standard seat with hardware Manual wheelchair accessory, solid seat)	N****	Purchase
E0994	NU EP		Armrest, each	N****	Purchase
E1002	NU EP		W/C accessory power seating system, tilt only	Y♦	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E1004	NU EP		W/C accessory, power seating system, recline only, with mechanical shear reduction	Y♦	Purchase
E1006	NU EP		W/C accessory, power seating system, combination tilt and recline, w/o shear reduction	Y	Purchase
E1007	NU EP		Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction	Y	Purchase
E1010	NU EP		W/C accessory, addition to power seating system, power leg elevation system, including leg rest, each	Y	Purchase
E1020	NU EP		⁂(Adjustable Contour Lateral Thigh Support) Residual limb support system for W/C	N****	Purchase
E1028	NU EP		Wheelchair accessory, manual swingaway, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	N	Purchase
E1029	NU EP		⁂(Ventilator Tray With Battery Tray) Wheelchair accessory, ventilator tray, fixed	Y	Purchase
E1030	NU EP		Wheelchair accessory, ventilator tray, gimbaled	Y	Purchase
E1050*	NU EP		Fully reclining W/C, fixed full-length arms, swing-away, detachable elevating legrests	N****	Purchase
E1060*	NU EP		Fully reclining W/C, detachable arms, desk or full-length, swing-away detachable, elevating legrests	Y♦	Purchase
E1070#	EP		⁂(A maximum use of three months only) Fully-reclining wheelchair, detachable arms, (desk or full-length) swing-away, detachable footrest/elevated legrest	Y	Rental only
E1084*	NU EP		Hemi W/C; detachable arms, desk or full-length, swing-away, detachable, elevating leg rests	N****	Purchase
E1086*	NU EP		Hemi W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1086*	NU EP	U1 U1	Hemi W/C, detachable arms, desk or full-length, swing-away detachable footrests	Y	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
E1088*	NU EP		High strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1090	NU EP		High-strength lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1092*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrests	Y♦	Purchase
E1093*	NU EP		Wide, heavy-duty W/C; detachable arms, desk or full-length arms, swing-away, detachable footrests	Y♦	Purchase
E1110*	NU EP		Semi-reclining W/C; detachable arms, desk or full-length, elevating legrest	Y♦	Purchase
E1161	NU EP		Manual adult size W/C, includes tilt in space	Y♦	Purchase
E1170*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable, elevating legrests	N****	Purchase
E1172*	NU EP		Amputee W/C; detachable arms, desk or full-length, without footrests or legrests	Y♦	Purchase
E1180*	NU EP		Amputee W/C; detachable arms, desk or full-length, swing-away, detachable footrests	Y♦	Purchase
E1200*	NU EP		Amputee W/C; fixed full-length arms, swing-away, detachable footrests	N****	Purchase
E1220*	NU EP		W/C, specially sized or constructed **(indicate brand name, model number, if any, and justification)**	Y	Manually Priced
E1225	NU EP		**(Folding Backrest, 8 Degree Bend, Low, 15" - 16") Manual W/C accessory, semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each	N****	Purchase
E1228	NU EP		**(Folding Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase
E1228	NU EP		**(Folding Straight Backrest, Low, (15" - 16") Special back height for W/C	N****	Purchase
E1228	NU EP		**(Folding Straight Backrest, Tall, 19" - 20") Special back height for W/C	N****	Purchase
E1228	NU EP	U1 U1	**(High back contour seat) Special back height for W/C	N****	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
E1228	NU EP	U2 U2	**(Positioning tall back) Special back height for W/C	N****	Purchase
E1230*	NU EP		Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1230	EP NU	U1 U1	Power operated vehicle (three- or four-wheel nonhighway), specify brand name and model number	Y♦	Purchase
E1232*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, with seating system	Y♦	Purchase
E1233*	EP		W/C, pediatric size, tilt-in-space, rigid, adjustable, without seating system	Y♦	Purchase
E1234*	EP		W/C, pediatric size, tilt-in-space, folding, adjustable, without seating system	Y♦	Purchase
E1235*	NU EP		Wheelchair, pediatric size, rigid, adjustable, with seating system	Y♦	Purchase
E1235[2]	EP	U1	**(Rigid W/C Frame) W/C, pediatric size, rigid, adjustable with seating system	Y	Purchase
E1236	EP		Wheelchair, pediatric size, folding, adjustable, with seating system	Y	Purchase
E1237*	EP		W/C, pediatric size, rigid, adjustable, without seating system	Y♦	Purchase
E1238*	EP		W/C, pediatric size, folding, adjustable, without seating system	Y♦	Purchase
E1240*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable, elevating legrest	Y♦	Purchase
E1260*	NU EP		Lightweight W/C; detachable arms, desk or full-length, swing-away, detachable footrests	N****	Purchase
E1280*	NU EP		Heavy-duty W/C; detachable arms, desk or full-length, elevating legrests	Y♦	Purchase
E1290*	NU EP		Heavy-duty W/C; detachable arms, swing-away, detachable footrests	Y♦	Purchase
E2201	NU EP		**(Seat Width 20") Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and < 24 inches	N****	Purchase
E2201	NU EP	U1 U1	**(Frame Width 14"-15") Manual w/c accessory, nonstandard seat frame width>than or equal to 20 inches and <24 inches	N****	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E2201	NU EP	U2 U2	**(Frame Width 19"-20") Manual w/c accessory, nonstandard seat frame width>than or equal to 20 inches and <24 inches	N****	Purchase
E2201	NU EP	U3 U3	Manual w/c accessory, nonstandard seat frame width > than or equal to 20 inches and <24 inches	N****	Manually Priced
E2203	NU EP		**(Seat Depth 15") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U1 U1	**(Seat Depth 17" - 18") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U2 U2	**(Frame, Long; 16", 17"3, 18", 19"3, 20" Depth) Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U3 U3	**(Seat Depth 19" - 20") Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N****	Purchase
E2203	NU EP	U4 U4	Manual w/c accessory, nonstandard seat frame depth, 20 to less than 22 inches	N	Manually Priced
E2206	NU EP		Manual wheelchair accessory, wheel lock assembly, complete, each	N	Purchase
E2207	NU EP		Wheelchair accessory, crutch and cane holder, each	N****	Purchase
E2208	NU EP		Wheelchair accessory, cylinder tank carrier, each	N	Purchase
E2209	NU EP		Wheelchair accessory, arm trough, each	N	Purchase
E2210	NU EP		Wheelchair accessory, bearings, any type, replacement only, each	N	Purchase
E2211	NU EP		Manual wheelchair accessory, pneumatic propulsion tire, any size, each	N	Purchase
E2212	NU EP		Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each	N	Purchase
E2213	NU EP		Manual wheelchair accessory, insert for pneumatic propulsion tire (removable), any type, any size, each	N	Purchase
E2214	NU EP		Manual wheelchair accessory, pneumatic caster tire, any size, each	N	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
E2215	NU EP		Manual wheelchair accessory, tube for pneumatic caster tire, any size, each	N	Purchase
E2220	NU EP		Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each	N	Purchase
E2221	NU EP		Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each	N	Purchase
E2226	NU EP		Manual wheelchair accessory, caster fork, any size, replacement only, each	N	Purchase
E2231	NU EP		Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware	Y	Purchase
E2291	EP		Back, planar, for pediatric size wheelchair, including fixed attaching hardware	N	Manually Priced
E2292	EP		Seat, planar, for pediatric size wheelchair, including fixed attaching hardware	N	Manually Priced
E2293	EP		Back, contoured, for pediatric size wheelchair, including fixed attaching hardware	N	Manually Priced
E2294	EP		Seat, contoured, for pediatric size wheelchair, including fixed attaching hardware	N	Manually Priced
E2295	EP		Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features	Y	Manually Priced
E2310	NU EP		Power w/c accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase
E2311	NU EP		Power w/c accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware	Y	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E2322	NU EP		Power w/c accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware	Y	Purchase
E2323	NU EP		Power w/c accessory, specialty joystick handle for hand control interface, prefabricated	Y	Purchase
E2324	NU EP		Power w/c accessory, chin cup for chin control interface	Y	Purchase
E2325	NU EP		Power w/c accessory, sip & puff interface nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware	Y	Purchase
E2326	NU EP		Power wheelchair accessory, breath tube kit for sip and puff interface ⁂ (replacement only)	Y	Purchase
E2327	NU EP		Power w/c accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware	Y	Purchase
E2359	NU EP		Power w/c accessory, group 34 sealed lead acid battery, each	N	Purchase
E2360	NU EP		Power w/c accessory, 22 NF non-sealed lead acid battery, each	N	Purchase
E2361	NU EP		Power w/c accessory, 22 NF sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP		Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2363	NU EP	U1 U1	Power w/c accessory, group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat)	N	Purchase
E2365	NU EP		⁂(U-1 gel cell battery, each) Power wheelchair accessory, U-1 sealed lead acid battery, each, (e.g., gel cell, absorbed glassmat)	N	Purchase
E2365	NU EP	U1 U1	Power w/c accessory, U-1 sealed lead acid battery, each, gel cell	N	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E2366	NU EP		**(24 Volt Battery Charger - Standard, Replacement) Power w/c accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each	N	Purchase
E2367	NU EP		**(24 Volt Battery Charger - Dual Mode, Replacement) Power w/c accessory, battery charger, dual mode, sealed or non-sealed, each	N	Purchase
E2368	NU EP		Power wheelchair component, motor, replacement only	N	Purchase
E2369	NU EP		Power wheelchair component, gear box, replacement only	N	Purchase
E2370	NU EP		Power wheelchair component, motor and gear box combination, replacement only	Y	Purchase
E2372	NU EP		Power wheelchair accessory, group 27 non-sealed lead acid battery, each	Y	Purchase
E2373	NU EP		Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixing mounting hardware.	Y	Purchase
E2375	NU EP		Power wheelchair accessory, nonexpandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2376	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only	Y	Purchase
E2377	NU EP		Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue	Y	Purchase
E2378	NU EP		Power wheelchair component, actuator, replacement only	Y	Purchase
E2381	NU EP		Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase
E2382	NU EP		Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each	Y	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
E2383	NU EP		Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each	Y	Purchase
E2384	NU EP		Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2385	NU EP		Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each	Y	Purchase
E2386	NU EP		Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each	Y	Purchase
E2387	NU EP		Power wheelchair accessory, foam caster tire, any size, replacement only, each	Y	Purchase
E2601	NU EP UE		General use wheelchair seat cushion, width less than 22 in., any depth	N****	Purchase
E2602	NU EP UE		General use wheelchair seat cushion, width 22 in. or greater, any depth	N	Purchase
E2611	NU EP UE		General use wheelchair back cushion, width less than 22 in., any height, including any type mounting hardware	N	Purchase
E2612	NU EP UE		General use wheelchair back cushion, width 22 in. or greater, any height, including any type mounting hardware	N	Purchase
E2619	NU EP		Replacement cover for wheelchair seat cushion or back cushion, each	N	Purchase
E2622	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth	N	Purchase
E2623	NU EP UE		Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth	N	Purchase
E2624	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width less than 22 inches, any depth	N	Purchase
E2625	NU EP UE		Skin protection and positioning wheelchair seat cushion, adjustable width 22 inches or greater, any depth	N	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
E2626	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable	Y	Purchase
E2627	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, adjustable Rancho type	Y	Purchase
E2628	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, reclining	Y	Purchase
E2629	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)	Y	Purchase
E2630	NU EP		Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support	Y	Purchase
E2631	NU EP		Wheelchair accessory, addition to mobile arm support, elevating proximal arm	Y	Purchase
E2632	NU EP		Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control	Y	Purchase
E2633	NU EP		Wheelchair accessory, addition to mobile arm support, supinator	Y	Purchase
K0004	NU EP		High-strength lightweight wheelchair	Y****	Purchase
K0005*	NU EP		**(High-performance manual W/C-adult) Ultralightweight W/C	Y♦	Purchase
K0005*	NU EP	U1 U1	**(High-performance manual W/C with growth adjustability-child) Ultralightweight W/C	Y♦	Purchase
K0010	NU EP		**(Motorized, standard frame, DA, swing away footrests) Standard weight frame motorized/power W/C	Y♦	Purchase
K0010	NU EP	U1 U1	**(Motorized, standard frame, DA, swing away ELR) Standard weight frame motorized/power W/C	Y♦	Purchase

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method
K0011	NU EP		⁂(Motorized, power base or conventional frame w/c DA/swing away footrests, programmable electronics and custom options) Standard-weight frame motorized/power, W/C with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Y♦	Purchase
K0011	NU EP	U1 U1	⁂(Motorized, power base or conventional frame w/c DA/swing away footrests, programmable electronics and custom options) Standard-weight frame motorized/power, W/C with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking	Y♦	Purchase
K0012	NU EP		⁂(Motorized folding frame, DA, swing away footrests) Lightweight portable motorized/power W/C	Y♦	Purchase
K0012	NU EP	U1 U1	⁂(Motorized folding frame, DA, swing away ELR) Lightweight portable motorized/power W/C	Y♦	Purchase
K0014[1,2]	NU EP		Other motorized/ power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U1 U1	⁂(Center Drive power base) Other motorized/ power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U3 U3	⁂ (Motorized, Power Base or conventional frame W/C DA/swing away foot rests, programmable electronics and custom options) Other motorized/ power W/C base	Y♦	Purchase
K0014[1,2]	NU EP	U4 U4	⁂ (Motorized, Power Base or conventional frame W/C DA/swing away elevated foot rests, programmable electronics and custom options) Other motorized/ power W/C base	Y♦	Purchase
K0017	NU EP		⁂(Receiver for height adjustable arms) Detachable, adjustable height armrest, base, each	N****	Purchase
K0017	NU EP	U1 U1	⁂(Dual post and adjustable height DA) Detachable, adjustable height armrest, base, each	N****	Purchase
K0019	NU EP		Arm pad, each	N	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
K0020	NU EP		Fixed, adjustable height armrest, pair	N****	Purchase
K0038**	EP	U1	**(Knee strap) Leg strap, each	N	Purchase
K0038	NU EP		**(Single leg strap, each) Leg strap, each	N****	Purchase
K0038	NU EP	U2 U2	**(Foot straps, pair) Leg strap, each	N****	Purchase
K0039	NU EP		Leg strap, H style, each	N****	Purchase
K0040	NU EP		Adjustable angle footplate, each	N****	Purchase
K0043	NU EP		**(SWFR, replacement) Footrest, lower extension tube, each	N	Purchase
K0044	NU EP		**(SWFR Hanger bracket, replacement) Footrest, upper hanger bracket, each	N****	Purchase
K0045	NU EP		**(Padded custom foot box) Footrest, complete assembly	N****	Purchase
K0047	NU EP		Elevating legrest, upper hanger bracket, each	N****	Purchase
K0056	NU EP		Seat height less than 17 inches or equal to or greater than 21 inches for a high-strength, lightweight, or ultralightweight W/C	N****	Manually Priced
K0056	NU EP	U1 U1	**(Seat height 19.5"5) Seat height less than 17 inches or equal to or greater than 21 inches for a high strength, lightweight or ultralightweight W/C	N****	Purchase
K0065	NU EP		Spoke protectors, each	N****	Purchase
K0070	NU EP		**(Wheel assembly, complete with pneumatic tires, 20"/22"/24"/26"/ea. replacement) Rear wheel assembly, complete with pneumatic tire, spokes or molded, each	N****	Purchase
K0071	NU EP	U1 U1	**(Wheel assembly with pneumatic tires, 22", pair, rear wheels) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase
K0071	NU EP		**(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with pneumatic tire, each	N****	Purchase

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National Procedure Code	M1	M2	Description	PA	Payment Method
K0072	NU EP		**(Polyurethane casters, 5", pair, front casters) Front caster assembly, complete, with semipneumatic tire, each	N****	Purchase
K0073	NU EP		Caster pin lock, each	N****	Purchase
K0077	NU EP		Front caster assembly, complete, with solid tire, each	N	Purchase
K0108	NU EP		**(W/C miscellaneous equipment; applicable pages from the manufacturer's catalog must be attached to the claim form.) Other accessories	Y	Manually Priced
K0739	NU EP	U1 U1	**(Labor only, Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable, 20 units=5 hours of labor)	Y	Purchase
S1002	EP		**(Wheelchair, custom molded seating system only) Customized item, list in addition to code for basic item	N****	Manually Priced
S1002	NU EP	U1 U1	**(Foam in place seat, Pindot quick foam contour system) Customized item, list in addition to code for basic item	N****	Purchase

The following procedure codes may only be billed on paper.

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National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0190	EP	UA	**(Adductor - no hardware)	N****	Purchase	Z2140
E0190	NU	UA	**(Adductor - no hardware)	N****	Purchase	Z2140
E0190	EP	UB	**(Abductor - no hardware)	N****	Purchase	Z2141
E0190	NU	UB	**(Abductor - no hardware)	N****	Purchase	Z2141
E0190	EP	UC	**(Hip guides - no hardware)	N	Purchase	Z2142
E0190	NU	UC	**(Hip guides - no hardware)	N	Purchase	Z2142
E0190	EP	UD	**(Laterals - no hardware)	N****	Purchase	Z2145
E0190	NU	UD	**(Laterals - no hardware)	N****	Purchase	Z2145
E0191	EP	U1	**(Elbow Block w/Bracket)	N****	Purchase	Z2203
E0191	NU	U1	**(Elbow Block w/Bracket)	N****	Purchase	Z2203

The following procedure codes may only be billed on paper.

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0700	EP	U3	PC Car Seat/Snug Seat	Y	Purchase	Z1824**
E0951 E0952	EP		Heel loop/holder, any type, with or without ankle strap, (ea) Shoe Holders S/M/L/XL	N****	Purchase	Z2183
E0951 E0952	NU		Heel loop/holder, any type, with or without ankle strap, (ea) Shoe Holders S/M/L/XL	N****	Purchase	Z2183
E0955	EP		Sub Occipital Three Piece Head Set w/REM Hardware	N****	Purchase	Z2188
E0955	NU		Sub Occipital Three Piece Head Set w/REM Hardware	N****	Purchase	Z2188
E0956	EP	U4	**(Lateral Hip/Thigh support w/hardware (ea))	N****	Purchase	Z2139
E0956	NU	U4	**(Lateral Hip/Thigh support w/hardware (ea))	N****	Purchase	Z2139
E0956	EP	U5	**(Rigid Side Guard)	N****	Purchase	Z2186
E0956	NU	U5	**(Rigid Side Guard)	N****	Purchase	Z2186
E0956	EP	U6	**(Fabric Side Guard)	N****	Purchase	Z2187
E0956	NU	U6	**(Fabric Side Guard)	N****	Purchase	Z2187
E0957	EP	U1	**(Adjustable Rem. Abductor w/hardware (ea))	N****	Purchase	Z2137
E0957	NU	U1	**(Adjustable Rem. Abductor w/hardware (ea))	N****	Purchase	Z2137
E0957	EP	U2	**(Adjustable Flip Down Abductor w/hardware (ea))	N****	Purchase	Z2138
E0957	NU	U2	**(Adjustable Flip Down Abductor w/hardware (ea))	N****	Purchase	Z2138
E0970	EP		SWFR Composite Foot Plate (Replacement)	N****	Purchase	Z2181
E0970	NU		SWFR Composite Foot Plate (Replacement)	N****	Purchase	Z2181
E0978	EP	U3	**(Forehead Strap System)	N****	Purchase	Z2189
E0978	NU	U3	**(Forehead Strap System)	N****	Purchase	Z2189
E1011	EP		Rigid Wheelchair Growth Kit Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	N	Purchase	Z2185

The following procedure codes may only be billed on paper.

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E1011	NU		Rigid Wheelchair Growth Kit Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair)	N	Purchase	Z2185
E1020	EP	U1	**(Adjustable Contour Lateral Pelvic Support)	N****	Purchase	Z2589
E1020	NU	U1	**(Adjustable Contour Lateral Pelvic Support)	N****	Purchase	Z2589
E1028	EP		Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory, Swing Away Mount (Joystick)	N****	Purchase	Z2616
E1028	NU		Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory, Swing Away Mount (Joystick)	N****	Purchase	Z2616
E2201	EP	U3	X-Tube Assembly Folding W/C (Replacement)	N****	Purchase	Z2184
E2201	EP		Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 20" & <24"	N****	Purchase	Z2184
E2201	NU		Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 20" & <24"	N****	Purchase	Z2184
E2201	EP	U1	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	NU	U1	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	EP	U2	Manual W/C Accessory, Non-standard Seat Frame Width, > or equal to 24" & <27"	N****	Purchase	Z2184
E2201	NU	U1	Manual W/C Accessory, Non-standard Seat Frame Depth, 22" to 25"	N****	Purchase	Z2184

The following procedure codes may only be billed on paper.

Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E2203	EP		Manual W/C Accessory, Non-standard Seat Frame Depth 20" to <22"	N****	Purchase	Z2184
E2203	EP	U1	Manual W/C Accessory, Non-standard Seat Frame Depth, 22" to 25"	N****	Purchase	Z2184
E2203	NU		Manual W/C Accessory, Non-standard Seat Frame Depth, > or equal to 20" & 24"	N****	Purchase	Z2184
E2210	NU EP		Power W/C Sleeve Top or Bottom Stem Bearing (Replacement)	N****	Purchase	Z2175
E2231	NU EP	U1	**(Growing Seat Pan)	N****	Purchase	Z2585
E2373	NU EP	U1	**(Remote Joystick Module)	N****	Purchase	Z2592
E2611	NU EP		General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware, Growing Back Upholstery	N****	Purchase	Z2586
E2611	NU EP	U1	**(Adjustable Back Upholstery)	N****	Purchase	Z2604
E2612	NU EP		General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	N****	Purchase	Z2586
E2619	NU EP		Air Exchange Seat Cover for Cushions (Replacement)	N	Purchase	Z2158
E2620	NU EP	U1	**(Deep Contour Back 20" Width)	N****	Purchase	Z2588
E2622	NU EP	U1	Fluid Flo-lite pad (Replacement)	N	Purchase	Z2159
K0045	NU EP		One-piece footboard (each)	N****	Purchase	Z1613
K0045	NU EP	U2	Custom foot platform	N****	Purchase	Z1793
K0108	NU EP	U4	**(Swing Away Adj. Stroller Handles)	Y	Purchase	Z2196
K0108	NU EP	U2	**(Quick Release Axle)	Y	Purchase	Z2582

~~The following procedure codes may only be billed on paper.~~

~~Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult (Section 242.191)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~Description~~	~~PA~~	~~Payment Method~~	~~Deleted Local Code~~
~~K0108~~	~~NU EP~~	~~U3~~	~~**(Transit Option)~~	~~Y~~	~~Purchase~~	~~Z2599~~

Required Documentation

Face-to-Face Examination

In order for Medicaid to provide reimbursement for a Power/motorized Wheelchair (PWC), Power Operated Vehicle (POV) (scooter) or specialized manual wheelchair, the following requirements must be met.

A. A face-to-face physician examination must be performed.

B. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.

C. The prescription must be written only **after** the face-to-face physician examination and assessment of mobility limitations have occurred and the medical history and physical examination is completed.

D. The prescription and the medical records documenting the in-person visit and examination report must be sent to the equipment supplier within forty-five (45) days of completion of the examination.

E. The physician may refer the beneficiary to a licensed/certified professional, a Physical Therapist (PT) or Occupational Therapist (OT) to perform a wheelchair assessment.

If the beneficiary is referred to a physical/occupational therapist before the physician completes the face-to-face examination, the physician must review the physical/occupational therapist's written report and perform the final examination. The forty-five (45)-day period begins on the date of the physician's final face-to-face examination and must be submitted with the prior authorization request.

The face-to-face examination must include:

A. History of the present condition(s) and past medical history that is relevant to mobility needs:

1. Symptoms that limit ambulation.
2. Diagnoses that are responsible for these symptoms.
3. Medications or other treatment for these symptoms.
4. Progression of ambulation difficulty over time.
5. Other diagnoses that may relate to ambulatory problems.
6. How far the patient can walk without stopping.
7. What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently being used.
8. What has changed to now require use of a power mobility device.
9. Ability to stand up from a seated position without assistance.

B. Physical examination that is relevant to mobility needs:

1. Beneficiary's weight and height.
2. Cardiopulmonary examination.
3. Musculoskeletal examination, arm and leg strength and range of motion.
4. Neurological examination, gait, balance and coordination.

The examination should be tailored to the individual patient's condition. The history should clearly establish the patient's functional abilities and limitations related to mobility and ambulation.

In addition to all other requirements, a power mobility device is covered by Medicaid **only** if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home.

Provider-created forms and letters are not a substitute for other required forms and will not be considered.

Additional Wheelchair Documentation

A. The purchase of a wheelchair for individuals twenty-one (21) years of age and over is limited to one wheelchair per five (5)-year period if medically necessary. A wheelchair is a dependable mobility base with positioning components. It has complex positioning capabilities and is designed to grow in width, depth and height to accommodate physical changes of its users, it is of use to people with certain medical conditions and serves a specific medical purpose related to the condition of the patient.

B. The purchase of a wheelchair for an individual twenty (20) years of age and under is limited to one per two (2)-year period, if medically necessary.

C. Payment is made for one wheelchair only as stipulated in A. and B. Backup and loaner D. wheelchairs are not covered by Arkansas Medicaid.

D. Requests for a wheelchair that is beneficial primarily in allowing the beneficiary to perform leisure or recreational activities only will be denied. It is not medical in nature. Wheelchairs are authorized for medical use only.

E. Strollers and stroller-like chairs of any kind are not covered by Arkansas Medicaid. A stroller is a four-wheeled, often collapsible, chair-like carriage. They are helpful to caregivers and are typically used for transportation. Although stroller and stroller-like chairs may be used to transport individuals with medical conditions, such items do not serve a medical purpose. Strollers and stroller-like chairs have no positioning components for medical use, cannot be modified for growth and accommodate changes in medical or physical condition, and cannot be self-propelled by the individual.

F. Prior authorization is required even when insurance pays primary to Medicaid. Explanation of benefits (EOB) of the other insurance must be submitted with the request.

G. All wheelchair requests require a manufacturer's brand and the model name of the base.

H. In the event a wheelchair is stolen, damaged in the home, or by vehicle or fire, a police/fire report, copy of the home owners/auto insurance coverage and detailed documentation of events leading to the loss/damage are required.

I. Mobility bases for car seats are not covered by Medicaid.

J. Options, accessories, and replacement parts that are medically necessary for wheelchairs that do not have specific HCPCS codes should be coded ~~K0108~~ (other accessories). The manufacturer's suggested retail price (MSRP) must be listed for each item coded ~~K0108~~,

and the MSRP quote to the DME provider must be included. The MSRP quote must not be altered by the DME provider. If the MSRP is altered in any way, the request will be denied.

K. In the event a beneficiary wishes to change services from one DME provider to another DME provider, an affidavit signed and dated by the beneficiary must be submitted with the request from the new DME provider.

L. The existence of a procedure code does not necessarily indicate coverage by Arkansas Medicaid.

M. The allowed amount of a POV includes all options and accessories that are provided at the time of initial issue. This includes but is not limited to batteries, battery chargers, seating systems, etc. All options and accessories provided at the initial issue of a Power-Operated Vehicle (POV) are included and should not be billed separately.

N. If coverage criteria is not met for a specific item requested, and Arkansas Medicaid determines that another item is more appropriate and meets medical necessity, that item will be authorized.

O. The wheelchair will significantly improve the beneficiary's ability to participate in Mobility Related Activities of Daily Living (MRADL) and the individual will use the wheelchair on a regular basis in the home.

P. The individual's home will provide adequate access between rooms, maneuvering space and surface for use of the requested wheelchair.

Non-Covered Items for Specialized Wheelchairs and Wheelchair Systems

A. Items that are deluxe in nature. Deluxe items are items of convenience that are not medically necessary. Deluxe items are often used for social purposes or convenience. Deluxe items include deluxe accessories which increase the cost of purchase or operation. Deluxe items and deluxe accessories are not covered by Arkansas Medicaid.

B. Items for use in hospitals, nursing home or other institutions.

C. Items for the beneficiary's comfort or the caregiver's convenience.

D. Two pieces of equipment that serve the same purpose.

E. Backup and loaner wheelchairs.

F. Wheelchairs that primarily allow the beneficiary to perform leisure or recreational activities.

G. Mobility bases for car seats.

H. Items that are not primarily used in the treatment of a disease, injury or illness.

I. Any items or item upgrades that add cost without improving the beneficiary's ability to perform Mobility Related Activities of Daily Living.

Warranty, Maintenance and Replacement of Specialized Wheelchairs and Wheelchair Systems

All standard durable medical equipment must have a manufacturer's warranty. If a DME provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, adjustments, replacements and maintenance. The warranty begins on the date of delivery (date of service) to the beneficiary. The DME provider must keep a copy of the warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

DME suppliers must furnish at least a minimum of six (6) months warranty for any adjustments to new wheelchairs at no charge.

Labor will not be covered for the initial chair and for parts and services that are under warranty.

242.192 Specialized Rehabilitative Equipment for Beneficiaries of All Ages 810-1-221

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

** **Indicates that providers may bill only for beneficiaries under age 21.**

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

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method
A8000	NU EP		Helmet, protective, soft, prefabricated, includes all components and accessories	N	Purchase
A8001	NU EP		Helmet, protective, hard, prefabricated, includes all components and accessories	N	Purchase
A8002	NU EP		Helmet, protective, soft, custom fabricated, includes all components and accessories	N	Purchase
A8003	NU EP		Helmet, protective, hard, custom fabricated, includes all components and accessories	N	Purchase
E0149	NU EP		⁂(4 Wheel Reverse Walker) Walker, heavy-duty, wheeled, rigid or folding, any type	N	Purchase
E0163	EP NU	U1 U1	⁂(Potty Chair - Small) Commode chair, stationary, with fixed arms	Y	Purchase
E0168	EP		⁂(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0168	EP	UB	⁂(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0168	NU		**(Adaptive Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	N	Purchase
E0168	NU	U1	**(Rehab Shower/Commode Chair) Commode chair, extra wide and/or heavy-duty, stationary or mobile, with or without arms, any type, each	Y♦	Purchase
E0241	NU EP		**(Bolt-on Sm. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U1 U1	**(Bolt-on Lg. Grab Bar) Bathroom wall rail, each	N	Purchase
E0241	NU EP	U2 U2	**(Bolt-on Med. Grab Bar) Bathroom wall rail, each	N	Purchase
E0245	NU EP		**(Adj. Bath Chair w/Back) Tub stool or bench	N	Purchase
E0245	NU EP	U2 U2	**(Padded Tub Transfer Bench) Tub stool or bench	N	Purchase
E0245	NU EP	U3 U3	**(30" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U4 U4	**(38" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U5 U5	**(47" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	U6 U6	**(56" Bath Chair) Tub stool or bench	N	Purchase
E0245	NU EP	UB UB	**(Non-padded tub transfer bench) Tub stool or bench	N	Purchase
E0246	NU EP		**(Clamp-on Tub Grab Bar) Transfer tub rail attachment	N	Purchase
E0637	NU EP		Combination sit-to-stand frame/table system, any size, including pediatric, with seat lift feature, with or without wheels	Y	Purchase
E0638	NU EP		Standing frame system, any size, with or without wheels	Y	Purchase
E0638	EP EP	U1 U2	Standing frame system, any size, with or without wheels	Y	Purchase
E0700	NU EP		**(Chin Guard for Safety Helmet, Sm.) Safety equipment, e.g., belt, harness or vest	N	Purchase
E0705	NU EP		Transfer device, any type, each	Y	Purchase

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method
E0911	NU EP		Trapeze bar, heavy-duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar	N	Capped Rental
E0950	NU EP	U1 U1	**(Tray for gait trainer) Wheelchair accessory, tray, each	N	Purchase
E1031**	EP		**(Transition Toddler Chair - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U1	**(Corner Chair w/Tray & Casters - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U2	**(Transition Toddler Chair - Lg.) Rollabout chair, any and all types with casters five inches or greater	Y	Purchase
E1031**	EP	U3	**(Corner Chair w/Tray & Casters - Lg.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U4	**(Bolster Chair w/Tray, Chest Support & Casters - Sm.) Rollabout chair, any and all types with casters five inches or greater	N	Purchase
E1031**	EP	U5	**(Low Back Activity Chair) Rollabout chair, any and all types with casters five inches or greater	Y	Purchase
E1035**	EP		**(Carrie Seat - Preschool) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035**	EP	U1	**(Carrie Seat - Elementary) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035**	EP	U2	**(Carrie Seat - Jr.) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y	Purchase
E1035	NU EP	U3 U3	**(Carrie Seat - Sm. Adult) Multi-positional patient transfer system, with integrated seat, operated by care giver	Y♦	Purchase
E8000	EP		**(14") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Purchase
E8000	EP	U1	**(19") Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Purchase
E8000	EP	U2	**(Intermediate) Gait trainer, pediatric size, posterior support, includes all accessories and components	Y	Purchase

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method
E8001	EP		**(14") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Purchase
E8001	EP	U1	**(19") Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Purchase
E8001	EP	U2	**(Intermediate) Gait trainer, pediatric size, upright support, includes all accessories and components	Y	Purchase
E8002	EP		**(14") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Purchase
E8002	EP	U1	**(19") Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Purchase
E8002	EP	U2	**(Intermediate) Gait trainer, pediatric size, anterior support, includes all accessories and components	Y	Purchase

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
A9300	EP	U3	**(Therapy Ball - Sm.)	N	Purchase	Z2038**
A9300	EP	U1	**(Therapy Ball - Med.)	N	Purchase	Z2039**
A9300	EP	U2	**(Therapy Ball - Lg.)	N	Purchase	Z2040**
E0143	EP	U1	**(Tyke Strider Walker w/2 Wheels)	N	Purchase	Z2094**
E0143	EP	U2	**(Tweener Strider Walker w/2 Wheels)	N	Purchase	Z2095**
E0143	EP	U2	**(Middle Strider Walker w/2 Wheels)	N	Purchase	Z2096**
E0143	EP	U4	**(Adult Strider Walker w/2 Wheels)	N	Purchase	Z2097
E0143	NU	U4	**(Adult Strider Walker w/2 Wheels)	N	Purchase	Z2097
E0149	EP		4 Wheel Reverse Walker	N	Purchase	Z2099 Z2100 Z2101 Z2102

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0149	NU		4 Wheel Reverse Walker	N	Purchase	Z2099 Z2100 Z2101 Z2102
E0149	EP	U1	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2104
E0149	NU	U1	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2104
E0149	EP		⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2105
E0149	NU	U2	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2105
E0149	EP	U3	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2106
E0149	NU	U3	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2106
E0149	EP	U4	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2107
E0149	NU	U4	⁂(4 Wheel Front Swivel Reverse Walker)	N	Purchase	Z2107
E0168	EP	U2	⁂(Lg. Toilet Support w/Hi Back)	N	Purchase	Z2074
E0168	NU	U2	⁂(Lg. Toilet Support w/Hi Back)	N	Purchase	Z2074
E0168	EP	U3	⁂(Sm. Toilet Support w/Hi Back)	N	Purchase	Z2075
E0168	NU	U3	⁂(Sm. Toilet Support w/Hi Back)	N	Purchase	Z2075
E0190	EP	U5	⁂(48" Side Lyer)	N	Purchase	Z2015**
E0190	KA	U5	⁂(48" Side Lver)	N	Purchase	Z2015**
E0190	EP	U6	⁂(72" Side Lyer)	N	Purchase	Z2016**
E0190	KA	U6	⁂(72" Side Lver)	N	Purchase	Z2016**
E0190	EP		Adj. Abduction Wedge w/hip stabilizer	N	Purchase	Z2002
E0190	NU		Adj. Abduction Wedge w/hip stabilizer	N	Purchase	Z2002
E0190	KA	U4	Adj. Abduction Wedge w/hip stabilizer	N	Purchase	Z2002
E0240	EP	U4	⁂(Bath Chair Headrest)	N	Purchase	Z2239

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0240	NU	U4	⁂(Bath Chair Headrest)	N	Purchase	Z2239
E0244	EP	U1	⁂(Toilet Seat Reducer Ring (Padded))	N	Purchase	Z2089
E0244	NU	U1	⁂(Toilet Seat Reducer Ring (Padded))	N	Purchase	Z2089
E0245	EP	U7	⁂(Lg. Wrap Around Bath Support)	N	Purchase	Z2072
E0245	NU	U7	⁂(Lg. Wrap Around Bath Support)	N	Purchase	Z2072
E0245	EP	U8	⁂(Sm. Wrap Around Back Support)	N	Purchase	Z2073
E0245	NU	U8	⁂(Sm. Wrap Around Back Support)	N	Purchase	Z2073
E0246	EP	U1	Diverter Valve for Handheld Shower	N	Purchase	Z2605
E0246	NU	U1	Diverter Valve for Handheld Shower	N	Purchase	Z2605
E0246	EP	U2	⁂(Flexible Shower Hose)	N	Purchase	Z2077
E0246	NU	U2	⁂(Flexible Shower Hose)	N	Purchase	Z2077
E0638	EP	U3	⁂(Sm. 51" Supine Stander)	Y♦	Purchase	Z1996
E0638	NU	U3	⁂(Sm. 51" Supine Stander)	Y♦	Purchase	Z1996
E0638	EP	U4	⁂(Lg. 71" Supine Stander)	Y♦	Purchase	Z1997
E0638	NU	U4	⁂(Lg. 71" Supine Stander)	Y♦	Purchase	Z1997
E0638	EP	U5	⁂(27" Prone Stander)	Y	Purchase	Z1998**
E0638	EP	U6	⁂(35" Prone Stander)	Y	Purchase	Z1999**
E0638	EP	U7	⁂(42" Prone Stander)	Y♦	Purchase	Z2000**
E0638	EP	U8	⁂(50" Prone Stander)	Y♦	Purchase	Z2001
E0638	NU	U8	⁂(50" Prone Stander)	Y♦	Purchase	Z2001
E0638	EP	UA	⁂(Up Rite Stander - Sm.)	Y	Purchase	Z2006**
E0638	EP	UB	⁂(Up Rite Stander - Med.)	Y	Purchase	Z2007**
E0638	EP	UA U1	⁂(Up Rite Stander - Lg.)	Y	Purchase	Z2008
E0638	NU	UA U1	⁂(Up Rite Stander - Lg.)	Y	Purchase	Z2008
E0641	EP	U2	⁂(Tumble Form Tri Stander w/Tray - Sm.)	Y♦	Purchase	Z2012**

The following list of codes may only be billed on paper.

Specialized Rehabilitative Equipment, All Ages (Section 242.192)

National Procedure Code	M1	M2	Description	PA	Payment Method	Deleted Local Code
E0641	EP	U1	⁂(Tumble Form Tri Stander w/Tray - Lg.)	Y♦	Purchase	Z2013**
E0700	EP	U4	⁂(Orthopedic Car Seat)	Y	Purchase	Z2047
E0700	NU	U4	⁂(Orthopedic Car Seat)	Y	Purchase	Z2047
E0950	EP	U9	⁂(Tray for Stander-Prone)	N	Purchase	Z2003
E0950	NU	U9	⁂(Tray for Stander-Prone)	N	Purchase	Z2003
E0950	EP	UA	⁂(Tray for Stander-Supine)	N	Purchase	Z2004
E0950	NU	UA	⁂(Tray for Stander-Supine)	N	Purchase	Z2004
E1031	EP	U6	⁂(Mobile Floor Sitter Med/Lg.)	N	Purchase	Z2021**
E1031	EP	U7	⁂(14" T&S High Back w/Support Activity Chair)	Y	Purchase	Z2045**
E1031	EP	U8	⁂(16" T&S High Back w/Support Activity Chair)	Y	Purchase	Z2046**
E1399	EP	U1	⁂(Tumble Form Feeder Seat - Sm.)	N	Purchase	Z2017**
E1399	EP	U2	⁂(Tumble Form Feeder Seat - Med.)	N	Purchase	Z2018**
E1399	NU	U2	⁂(Tumble Form Feeder Seat - Med.)	N	Purchase	Z2018**
E1399	EP	U3	⁂(Tumble Form Feeder Seat - Lg.)	N	Purchase	Z2019**
E8002	EP	U3	⁂(Adult Gait Trainer)	Y♦	Purchase	Z2093
E8002	NU	U3	⁂(Adult Gait Trainer)	Y♦	Purchase	Z2093
K0045	EP	U1	⁂(Foot Sandals for Standers)	N	Purchase	Z2005
K0045	NU	U1	⁂(Foot Sandals for Standers)	N	Purchase	Z2005
K0071	EP	U1	⁂(Caster Base for Up Rite Stander - Sm.)	N	Purchase	Z2009
K0071	NU	U1	⁂(Caster Base for Up Rite Stander - Sm.)	N	Purchase	Z2009
K0071	EP	U2	⁂(Caster Base for Up Rite Stander - Med.)	N	Purchase	Z2010
K0071	NU	U2	⁂(Caster Base for Up Rite Stander - Med.)	N	Purchase	Z2010
K0071	EP	U3	⁂(Caster Base for Up Rite Stander - Lg.)	N	Purchase	Z2011
K0071	NU	U3	⁂(Caster Base for Up Rite Stander - Lg.)	N	Purchase	Z2011

242.193 Speech Generating Device for Beneficiaries of All Ages ~~1~~10-1-2~~2~~1

The speech generating device must be billed using the procedure code assigned to each component. The specific components will be reimbursed, as needed, for the procedure codes listed below and will count toward the lifetime limit of $7,500 per beneficiary.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

NOTE: Attach a manufacturer's invoice to the claim and indicate the item or parts billed on the invoice. A description and the amount billed for each item must be attached to the claim. If more than one item is billed under a procedure code, the description and billed amount of each item must be listed separately under each procedure code and attached to the claim. The total billed for each procedure code should be reflected in field 24F.

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

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

~~Speech Generating Device, All Ages (Section 242.193)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~PA~~	~~Description~~	~~Payment Method~~
~~E2500~~	~~NU EP~~		~~Y♦~~	~~⁂(Light Technology Communication Aids - communication aids that do not have the memory component to store the information. They are often used in conjunction with higher tech devices as part of a multi-modal communication system.) Speech-generating device, digitized speech, using pre-recorded messages less than or equal to 8 minutes recording time~~	~~Purchase~~
~~E2502~~	~~NU EP~~		~~Y♦~~	~~⁂(Simple Voice Output Device - simple devices with limited storage capacity and voice output only.) Speech-generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time~~	~~Purchase~~

Speech Generating Device, All Ages (Section 242.193)

National Procedure Code	M1	M2	PA	Description	Payment Method
E2504	NU EP		Y♦	**(Simple Voice Output Device - simple devices with limited storage capacity and voice output only) Speech-generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time	Purchase
E2506	NU EP		Y♦	**(Simple Voice Output Device - simple devices with limited storage capacity and voice output only) Speech-generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time.	Purchase
E2508	NU EP		Y♦	**(More Advanced Voice Output Communication Aids - offer more storage capacity and often have other output methods in addition to voice output; e.g., LED display) Speech-generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device	Purchase
E2510	NU EP		Y♦	**(Higher Technology Voice Output Communication Aids - offer greater memory capabilities, various types of output, computer interface options, etc.) Speech-generating device synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase
E2510	NU EP		Y♦	**(State-of-the-Art Voice Output Communication Aids - represents state-of-the-art communication aid technology. Have extensive memory capabilities, various output methods, computer interface options; offer a variety of input methods in a single device and advanced functions such as auditory scanning, icon and word prediction, etc.) Speech generating device synthesized speech, permitting multiple methods of message formulation and multiple methods of device access	Purchase
E2511	NU EP		Y♦	**(Software - often recommended for speech generating device. Software may change as the child matures.) Speech-generating software program, for personal computer or personal digital assistant	Purchase
E2512	NU EP		Y	Accessory for speech generating device, mounting system	Manually Priced

~~Speech Generating Device, All Ages (Section 242.193)~~

~~National Procedure Code~~	~~M1~~	~~M2~~	~~PA~~	~~Description~~	~~Payment Method~~
~~E2599~~	~~NU EP~~		~~Y♦~~	~~⁂(Switches - used with training aids and speech generating devices as a means of access) Accessory for speech generating device, not otherwise classified~~	~~Manually Priced~~
~~V5336~~	~~NU EP~~	~~RP RP~~	~~Y~~	~~⁂(Speech Generating Device Repair - **parts only**) Repair/modification of speech generating system or device (excludes adaptive hearing aid)~~	~~Manually Priced~~
~~V5336~~	~~NU EP~~		~~Y~~	~~⁂(Speech Generating Device Repair - **labor only**) Repair/modification of speech generating system or device (excludes adaptive hearing aid)~~	~~Manually Priced~~

Note: When repair charges for both parts and labor of the SGD is provided and/or billed on the same date of service, only one detail (parts only or labor only) of procedure code ~~V5336~~ may be billed per beneficiary per date of service. Information must be specified on the paper claim to clarify the charges billed by the provider. Parts and labor charges must be itemized by narrative and documentation.

A. The charge for parts must be clearly documented. A manufacturer's invoice for the parts must be attached.

B. The labor charge and the time represented by the labor charge must be clearly documented.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems ~~810~~-1-2~~21~~

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used. See **Section 242.191**.

E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**

F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.

G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.

H. Arkansas Medicaid will not cover repairs/damage due to the following:

1. Neglect.
2. Misuse.
3. Abuse.
4. Improper installation or repair by the DME provider.
5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.

I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.

J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

Miscellaneous

A. Only a physician can order a wheelchair.

B. A physician's evaluation is valid for a period of six (6) months. After six (6) months, the beneficiary must be re-evaluated by the physician to determine medical necessity for continued need based upon changes in conditions and measurements.

A DME request is considered outdated by Medicaid when it is first presented to Medicaid more than ninety (90) days from the date it was written, signed and dated by the physician.

242.402 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-22~~1~~

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

TOC not required

242.100 Procedure Codes

10-1-14221

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

HCPCS procedure code Q4141 must be billed on a paper claim with the manufacturer's invoice attached.

242.121 CPT Procedure Codes: Therapy

10-13-03-221

The CPT procedure codes that are payable to a rehabilitative hospital are as follows:

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

TOC not required

252.101 Billing Instructions for Family Planning Visits

~~6-15-10~~10-1-~~22~~4

Effective on and after April 30, 2010, all claims submitted from RHC providers for family planning visits are to use the following billing protocol, regardless of the date of service. No RHC family planning visits should be billed under the physician's provider number. The revised billing protocol will allow correct payment according to the benefit limit for eligible Arkansas Medicaid beneficiaries.

Rural Health Clinic providers are to bill revenue codes **0524** (for Independent RHCs) and **0525** (for Provider-Based RHCs), as well as an applicable procedure code and modifier. Procedure code ~~99402~~ with modifier **U9** will be used for the basic family planning visit, and ~~99401~~ with modifier **U9** will be used for the periodic family planning visit. This is shown in the following table. RHC basic and periodic family planning visits are billable electronically and on paper claim forms. All family planning services require a primary diagnosis of family planning on the claim.

~~Revenue Code~~	~~Description~~	~~Procedure Code~~	~~Description~~	~~Modifier~~
~~0524~~	~~Basic or Periodic Family Planning Visit Independent RHC~~	~~99401~~	~~Periodic Family Planning Visit~~	~~U9~~
~~0524~~	~~Basic or Periodic Family Planning Visit Independent RHC~~	~~99402~~	~~Basic Family Planning Visit~~	~~U9~~
~~0525~~	~~Basic or Periodic Family Planning Visit Provider-Based RHC~~	~~99401~~	~~Periodic Family Planning Visit~~	~~U9~~
~~0525~~	~~Basic or Periodic Family Planning Visit Provider-Based RHC~~	~~99402~~	~~Basic Family Planning Visit~~	~~U9~~

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.102 Billing Instructions for EPSDT and ARKids First-B Medical Screenings

~~9-1-14~~10-1-~~22~~4

Effective on or after April 30, 2010, all claims submitted by RHC providers for EPSDT and ARKids First-B medical screens performed by RHC personnel are to use the following billing protocol, regardless of the date of service. No screens should be billed under the physician's provider number. **However, if the screens were billed earlier under the physician's provider number, do not re-bill.** RHC providers are to bill the appropriate screen codes and modifiers. Each RHC's individual encounter rate will now be reimbursed when the RHC bills one of these medical screen procedure codes with the correct modifier(s). However, the encounter rate will only be reimbursed if the charge for the service submitted on the claim is greater than or equal to the RHC's encounter rate. The RHC will be reimbursed the lesser of the billed amount or their encounter rate.

Example – If an RHC's encounter rate is $75 and the RHC submits a screen claim with a billed amount of $85, the RHC will be reimbursed the lesser $75 encounter rate. If the same RHC submits a screen claim with a billed amount of $70, the RHC will be

reimbursed the $70 lesser amount and not the encounter rate. Screens are billable electronically and on paper claims.

For ARKids First-A (EPSDT) electronic billing, medical screens will require the electronic 837P with the special program indicator “01” in the header, along with the appropriate certification condition indicator and code. At the detail level, the procedure code will be billed with the EP modifier and the second modifier. For ARKids First-A (EPSDT) paper billing, providers will bill on the CMS-1500 claim form using the EP modifier and the second modifier. See the Physician provider manual for more information.

For ARKids First-B (ARKids First) electronic billing, medical screens will require the 837P without the special program indicator (professional electronic claim) with no modifier except for newborn care procedures, which require a UA modifier. For ARKids First-B (ARKids First) paper billing, providers will bill on the CMS-1500 claim form with no modifier except for newborn care procedure codes, which require a UA modifier. See the ARKids First provider manual for more information.

This billing protocol is shown in the following table.

View or print the procedure codes for Rural Health Clinic (RHC) services.

~~Description~~	~~Procedure Code~~	~~Mod #1~~	~~Mod #2~~
~~EPSDT Periodic Complete Medical Screen (New Patient)~~	~~99381~~	~~EP~~	~~U1~~
~~EPSDT Periodic Complete Medical Screen (New Patient)~~	~~99382~~	~~EP~~	~~U1~~
~~EPSDT Periodic Complete Medical Screen (New Patient)~~	~~99383~~	~~EP~~	~~U1~~
~~EPSDT Periodic Complete Medical Screen (New Patient)~~	~~99384~~	~~EP~~	~~U1~~
~~EPSDT Periodic Complete Medical Screen (New Patient)~~	~~99385~~	~~EP~~	~~U1~~
~~EPSDT Periodic Complete Medical Screen (New Foster Care Patient)~~	~~99381~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (New Foster Care Patient)~~	~~99382~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (New Foster Care Patient)~~	~~99383~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (New Foster Care Patient)~~	~~99384~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (New Foster Care Patient)~~	~~99385~~	~~EP~~	~~H9~~
~~ARKids Complete Medical Screen (New Patient)~~	~~99381~~		
~~ARKids Complete Medical Screen (New Patient)~~	~~99382~~		
~~ARKids Complete Medical Screen (New Patient)~~	~~99383~~		
~~ARKids Complete Medical Screen (New Patient)~~	~~99384~~		
~~ARKids Complete Medical Screen (New Patient)~~	~~99385~~		
~~EPSDT Periodic Complete Medical Screen (Established Patient)~~	~~99391~~	~~EP~~	~~U2~~
~~EPSDT Periodic Complete Medical Screen (Established Patient)~~	~~99392~~	~~EP~~	~~U2~~
~~EPSDT Periodic Complete Medical Screen (Established~~	~~99393~~	~~EP~~	~~U2~~

~~Description~~	~~Procedure Code~~	~~Mod #1~~	~~Mod #2~~
~~Patient)~~			
~~EPSDT Periodic Complete Medical Screen (Established Patient)~~	~~99394~~	~~EP~~	~~U2~~
~~EPSDT Periodic Complete Medical Screen (Established Patient)~~	~~99395~~	~~EP~~	~~U2~~
~~EPSDT Periodic Complete Medical Screen (Established Foster Care Patient)~~	~~99391~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (Established Foster Care Patient)~~	~~99392~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (Established Foster Care Patient)~~	~~99393~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (Established Foster Care Patient)~~	~~99394~~	~~EP~~	~~H9~~
~~EPSDT Periodic Complete Medical Screen (Established Foster Care Patient)~~	~~99395~~	~~EP~~	~~H9~~
~~ARKids Complete Medical Screen (Established Patient)~~	~~99391~~		
~~ARKids Complete Medical Screen (Established Patient)~~	~~99392~~		
~~ARKids Complete Medical Screen (Established Patient)~~	~~99393~~		
~~ARKids Complete Medical Screen (Established Patient)~~	~~99394~~		
~~ARKids Complete Medical Screen (Established Patient)~~	~~99395~~		
~~EPSDT Newborn Care/Screen in Hospital~~	~~99460~~	~~EP~~	~~UA~~
~~EPSDT Newborn Care/Screen in Hospital~~	~~99461~~	~~EP~~	~~UA~~
~~EPSDT Newborn Care/Screen in Hospital~~	~~99463~~	~~EP~~	~~UA~~
~~Newborn Care/Screen in Hospital~~	~~99460~~	~~UA~~	
~~Newborn Care/Screen in Hospital~~	~~99461~~	~~UA~~	
~~Newborn Care/Screen in Hospital~~	~~99463~~	~~UA~~	

252.103 Billing of Multi-Use and Single-Use Vials

~~11-1-15~~10-1-22~~1~~

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

View or print the procedure codes for Rural Health Clinic (RHC) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.401 Upper Respiratory Infection – Acute Pharyngitis

~~9-1-2010~~-1-~~22~~1

A Rural Health Center (RHC) must submit a claim that includes CPT code ~~87430, 87650, 87651, 87802, or 87880~~ in the Upper Respiratory Infection (URI)-Acute Pharyngitis episode if a strep test is performed when prescribing an antibiotic for beneficiaries. This allows DMS to determine if the Principle Accountable Provider (PAP) met or exceeded the quality threshold in order to qualify for a full positive supplemental payment for the URI-Pharyngitis episode.

View or print the procedure codes for Rural Health Clinic (RHC) services.

TOC not required

272.110 Mental Health Diagnosis

~~4-1-18~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~90791, U4~~	Psychiatric diagnostic evaluation (with no medical services)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (Plan of Care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1

APPLICABLE POPULATIONS	SPECIAL BILLING INSTRUCTIONS
Children and Youth	**Outpatient Behavioral Health Services Providers cannot bill ~~90791~~ on same date of service** **View or print the procedure codes for SBMH services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**

Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.120 Psychological Evaluation

~~4-1-18~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~96101, U4~~	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions; • history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a	• Date of service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes

psychiatric/diagnostic interview, observation in therapy or an assessment for level of care at a mental health facility.	• Treatment recommendations and findings related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Psychological Examiner (LPE) • Psychologist	03	

272.130 Interpretation of Diagnosis

~~4-1-18~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.~~90887, U4~~	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**

For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.140 Marital/Family Behavioral Health Counseling with Beneficiary Present

~~4-1-18~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~90847, U4, U6~~	Family psychotherapy with patient present (conjoint psychotherapy)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used, that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant release of Information, completed, signed and dated

NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12

APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**
Children and Youth	
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS)	03

• Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	

272.150 Crisis Intervention

~~4-1-18~~10-1-~~22~~1

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~H2011, U4, HA~~	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

Mental Health Diagnosis (90791) within 7 days of provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.160 Individual Behavioral Health Counseling

~~4-1-18~~10-1-~~22~~4

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~90832, U4~~ ~~90834, U4~~ ~~90837, U4~~	~~90832:~~ psychotherapy, 30 min ~~90834:~~ psychotherapy, 45 min ~~90837:~~ psychotherapy, 60 min
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based with an emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this	• Date of service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and

<table>
<tr><td>service.</td><td colspan="2">prognosis
• Any revisions indicated for the master treatment plan, diagnosis or medication(s)
• Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.</td><td>~~90832:~~ 30 minutes
~~90834:~~ 45 minutes
~~90837:~~ 60 minutes
View or print the procedure codes for SBMH services.</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED:
~~90832:~~ 1
~~90834: 1~~
~~90837: 1~~

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested):
12 units</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children and Youth</td><td colspan="2">A provider may only bill one individual counseling/psychotherapy code per day per beneficiary. A provider cannot bill any other individual counseling/psychotherapy code on the same date of service for the same beneficiary.</td></tr>
<tr><th>ALLOWED MODE(S) OF DELIVERY</th><th colspan="2">TIER</th></tr>
<tr><td>Face-to-face</td><td colspan="2">School-Based Mental Health</td></tr>
<tr><th>ALLOWABLE PERFORMING PROVIDERS</th><th colspan="2">PLACE OF SERVICE (POS)</th></tr>
<tr><td>• Licensed Certified Social Worker (LCSW)
• Licensed Master Social Worker (LMSW)
• Licensed Professional Counselor (LPC)
• Licensed Associate Counselor (LAC)
• Licensed School Psychology Specialist (LSPS)
• Licensed Psychological Examiner (LPE)
• Psychologist

* School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.</td><td colspan="2">03</td></tr>
</table>

272.170 Group Outpatient – Group Therapy

~~4-1-18~~10-1-22~~4~~

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.~~90853, U4~~	A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and remediation of psychiatric condition.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group • Brief mental status and observations • Rationale for group counseling must coincide with master treatment plan • Beneficiary's response to the group counseling that includes current progress or regression and prognosis • Any changes indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next group session, including any homework assignments • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 12 units Rehabilitative/Intensive Level Beneficiary: 104 units

same group). Providers may bill for services only at times during which beneficiaries participate in group activities.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling visits allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 104 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72	

TOC not required

215.000 Covered Air Ambulance Services

~~10-13-03~~-221

Please refer to Section 241.100 for reimbursement information. Please refer to **Section 252.100** for covered air ambulance services and the payable procedure codes.

241.100 Air Ambulance

~~10-13-03~~-221

Arkansas Medicaid reimburses turboprop, piston propelled and jet aircraft air ambulance services per hour of services (medical services) and per mileage (aircraft operating costs). The hourly rate will only be reimbursed for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing.

Arkansas Medicaid will reimburse ground transport salary and fringe expenses for the aircraft medical crew up to a maximum of $1,000 per total roundtrip flight for air nursing crew and air paramedic crew procedure codes. (See **Section 252.100** for procedure codes.) This reimbursement can only be made for medical crew assistance time while:

A. The crew travels to the hospital to pick up the patients;

B. The patient is being transported from the original hospital to the aircraft;

C. The patient is being transported from the aircraft to the receiving hospital and

D. The crew is traveling back to the aircraft after delivering the patient to the receiving hospital.

The ground transport medical crew time is reimbursable whether or not the crew actually accompanies the patient in the ground transport ambulance. The crew may travel in a separate vehicle, if necessary.

Arkansas Medicaid will reimburse air transport ventilator and respiratory therapist services. This service will only be reimbursed, when necessary, for patient care during transportation.

252.100 Ambulance Procedure Codes

~~8-3-2010-1-~~221

The covered ambulance procedure codes are listed below.

View or print the procedure codes for Transportation (Ambulance) services.

Drug procedure codes require National Drug Codes (NDC) billing protocol. See Section 252.110 below.

~~A0382~~	~~A0398~~	~~A0422~~	~~A0425~~	~~A0426~~	~~A0427~~	~~A0428~~	~~A0429~~
~~J0150*~~	~~J0171*~~	~~J0280*~~	~~J0461*~~	~~J1094*~~	~~J1100*~~	~~J1160*~~	~~J1200*~~
~~J1265~~	~~J1940*~~	~~J2060*~~	~~J2175*~~	~~J2270*~~	~~J2310*~~	~~J2550*~~	~~J2560*~~
~~J3360*~~	~~J3410*~~	~~J3475*~~	~~J3480*~~	~~J3490*~~	~~93041*~~		

*Procedure code can be billed only in conjunction with procedure code~~A0426 and~~ **~~A0427~~**
(please keep all documentation supporting the medical necessity of all codes billed for retrospective review of claims).

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. 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 payable CPT code ranges ~~96365 through 96379~~.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

~~Procedure Code~~	~~Required Modifier~~	~~Description~~
~~A0422~~	~~U1~~	~~Emergency, oxygen, helicopter air ambulance~~
~~A0425~~		~~Ground mileage per statute mile~~
~~A0431~~		~~Ambulance service, emergency, basic pick-up, helicopter, one unit per day~~
~~A0434~~		~~Air Ventilator/Respiratory Therapist, one unit equals one hour (Round to the nearest hour)~~
~~A0435~~	~~U1, UB~~	~~Piston propelled fixed wing air ambulance per mile~~
	~~U2, UB~~	~~Turboprop fixed wing air ambulance per mile~~
	~~U3, UB~~	~~Jet (fixed wing) one unit equals one mile~~
	~~U4, UB~~	~~Piston propelled fixed wing air ambulance per hour (Round to the nearest hour)~~
	~~U5, UB~~	~~Turboprop fixed wing air ambulance per hour (Round to the nearest hour)~~
	~~U6, UB~~	~~Jet (fixed wing) one unit equals one hour (Round to the nearest hour)~~
~~A0436~~		~~Emergency, per mile, loaded, helicopter air ambulance~~

TOC not required

242.100 Ventilator Equipment and Supplies Procedure Codes

~~1-25-19~~10-1-242

View or print the procedure codes for Ventilator services.

Procedure codes must be billed either electronically or on paper with the modifiers indicated.

Prior authorization requirements are shown under the heading PA.

[1]Code may only be billed for a ventilator patient in his or her home. The code is not covered for a ventilator patient in a nursing facility.

[2]Bill only for beneficiaries under age 21.

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

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

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~	~~PA~~	~~Maximum Units~~	~~Payment Method~~
~~A4483~~		~~⁂ (non-vent, trach nose) Moisture exchanger, disposable, for use with invasive mechanical ventilation~~	~~No~~	~~N/A~~	~~Purchase~~
~~E0250[1]~~		~~Hospital bed, fixed height, with any type side rails, with mattress~~	~~Yes*~~	~~1 per day (1 day = 1 unit)~~	~~Capped Rental~~
~~E0255[1]~~		~~Hospital bed, variable height, hi-lo, with any type side rails, with mattress~~	~~Yes*~~	~~1 per day (1 day = 1 unit)~~	~~Capped Rental~~
~~E0260[1]~~		~~Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress~~	~~Yes*~~	~~1 per day (1 day = 1 unit)~~	~~Capped Rental~~
~~E0424[1]~~		~~Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator flowmeter, humidifier, nebulizer, cannula or mask, and tubing~~	~~Yes*~~	~~1 per day (1 day = 1 unit)~~	~~Rental Only~~
~~E0430[1]~~		~~Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing~~	~~Yes*~~	~~1 per day (1 day = 1 unit)~~	~~Rental Only~~

Procedure Code	Modifier(s)	Description	PA	Maximum Units	Payment Method
E0435[1]		Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter	Yes*	1 per day (1 day = 1 unit)	Rental Only
E0439[1]		Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes*	1 per day (1 day = 1 unit)	Rental Only
E0465		Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0465	UB	⁂(Ventilator supplies – Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies.) Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Purchase
E0465	U1	⁂(Used equipment) Home Ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0466	U1	⁂Negative pressure ventilator; portable or stationary	Yes	1 per day (1 day = 1 unit)	Rental Only
E0466		Home Ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)	Yes	1 per day (1 day = 1 unit)	Rental Only
E0500		IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	Yes	1 per day	Rental Only
E0570[1]		Nebulizer with compressor	Yes*	1 per day (1 day = 1 unit)	Purchase Only

~~Procedure Code~~	~~Modifier(s)~~	~~Description~~	~~PA~~	~~Maximum Units~~	~~Payment Method~~
~~E0600[1]~~		~~Respiratory suction pump, home model, portable or stationary, electric~~	~~No~~	~~1 per day (1 day = 1 unit)~~	~~Rental Only~~
~~E0600[1]~~	~~U1~~	~~Suction pump, home model, portable (used equipment)~~	~~Yes~~	~~1 per day (1 day = 1 unit)~~	~~Rental Only~~
~~E1390~~		~~Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate~~	~~Yes*~~	~~1 per day~~	~~Rental Only~~
~~G0237[2]~~ ~~G0238[2]~~	~~EP, UA~~ ~~EP, UA~~	~~Respiratory therapy services for ventilator-dependent patients~~	~~Yes~~	~~Frequency of visits as prescribed~~	~~N/A~~

242.310 Completion of CMS-1500 Claim Form

~~9-1-14~~10-1-~~22~~1

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.

Field Name and Number		Instructions for Completion
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.

Field Name and Number			Instructions for Completion
		SEX	Not required.
	b.	OTHER CLAIM ID NUMBER	Not required.
	c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
	d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12.		PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13.		INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14.		DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15.		OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16.		DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.		NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary care physician (PCP) referral is not required for ventilator equipment services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.

Field Name and Number	Instructions for Completion
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.

Field Name and Number	Instructions for Completion
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from **Section 242.100**.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

214.200 Coverage and Limitations of the Under Age 21 Program

~~7-1-17~~10-1-~~22~~4

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization. There will be no co-payment assessed for replacement glasses requiring prior authorization.
3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.
4. EPSDT beneficiaries will have no co-pays. ARKids First-B beneficiaries will be assessed a $10.00 co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses.

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

I. Prior authorized orthoptic and/or pleoptic training ~~(procedure code 92065)~~ may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under.

1. The initial prior authorization request must include objective and subjective measurements and tests used to indicate diagnosis.
2. The initial prior authorization approved for this treatment will consist of sixteen (16) treatments in a twelve (12)-month period with no more than one treatment per seven (7) calendar days.
3. An extension of benefits may be requested for medical necessity.
4. Requests for extension of benefits must include the initial objective and subjective measures with diagnosis along with subjective and objective measures after the initial sixteen (16) treatments are completed to show progress and the need for, or benefit of, further treatment.
5. For a list of diagnoses that are covered for orthoptic and/or pleoptic training **(View ICD Codes.)**.

J. Prior authorized sensorimotor examination ~~(procedure code 92060)~~ may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) sensorimotor examination in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for sensorimotor examination **(View ICD Codes.)**.

K. Prior authorized developmental testing ~~(procedure code 96111)~~ may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) developmental testing in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for developmental testing **(View ICD Codes)**.

View or print the procedure codes for Vision services.

242.110 Visual Procedure Codes

~~7-1-17~~10-1-~~22~~1

The following services are covered under the Arkansas Medicaid Program. "W/PA" means that a service requires prior authorization.

View or print the procedure codes for Vision services.

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
DIAGNOSTIC AND ANCILLARY SERVICES				
S0620	—	ROUTINE OPTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION; NEW PATIENT This service must include the following: case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination. It may also include initiation of diagnostic and treatment programs or referral.	yes	yes
S0621	—	ROUTINE OPTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION; ESTABLISHED PATIENT This service must include the following: case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination. It may also include initiation of diagnostic and treatment programs or referral.	yes	yes
92340	—	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA: MONOFOCAL Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography.	yes	yes
92370	—	REPAIR AND REFITTING OF SPECTACLES Repair and refitting spectacles; except for aphakia	yes	yes W/PA
99173	UB	SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BILATERAL This procedure must include at a minimum three components listed under procedure code S0620 or S0621. This code may not be billed in conjunction with procedure code S0620 or S0621.	yes	yes

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
CONTACT LENS SERVICES				
S0592	—	COMPREHENSIVE CONTACT LENS EVALUATION This service must include the following: biomicroscopy, multiple ophthalmometry, case history, tear flow, measurement of ocular adnexa, initial tolerance evaluation, and may include other tests. This procedure does not include contact lens and should be billed in conjunction with other contact lens procedure codes.	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (SOFT) Spherical, aphakic, lenticular, toric, hydrophilic (per lens)	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (GAS PERMEABLE) Spherical, aphakic, lenticular, toric, prism ballast (per lens)	yes W/PA	yes W/PA
V2501	UA	SUPPLYING AND FITTING OF KERATOCONUS LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF MONOCULAR LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA
V2501	U1	SUPPLYING AND FITTING OF MONOCULAR LENS (SOFT LENS) - per lens	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (SOFT) Spherical, aphakic, lenticular, toric, hydrophilic (per lens)	yes W/PA	yes W/PA
S0500	—	DISPOSABLE CONTACTS (PER LENS)	yes W/PA	yes W/PA
LOW VISION SERVICES				
92002		OPHTHALMOLOGICAL SERIVICES: Medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	yes	yes
SUPPLEMENTAL PROCEDURES				
92081	—	VISUAL FIELD EXAMINATION Unilateral or bilateral, with interpretation and report; limited examination	yes	yes
92082	—	VISUAL FIELD EXAMINATION Unilateral or bilateral, with interpretation and report; intermediate examination	yes	yes

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
92083	—	VISUAL FIELD EXAMINATION Unilateral or bilateral, with interpretation and report; extended examination	yes	yes
MISCELLANEOUS SERVICES				
92100		TONOMETRY This procedure will only be covered when medically necessary. These conditions include, but are not limited to, diabetes, hypertension and age of the patient.	yes	yes
92065	—	ORTHOPTIC AND PLEOPTIC TRAINING WITH CONTINUING MEDICAL DIRECTION AND EVALUATION	yes W/PA	no
92060	—	SENSORIMOTOR EXAMINATION With multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure).	yes W/PA	no
96111	—	DEVELOPMENTAL TESTING Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.	yes W/PA	no
CONTACT LENS REPLACEMENT				
92326	—	HARD LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	yes W/PA
92326	—	SOFT LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	yes W/PA
92326	—	GAS PERMEABLE (PER LENS) This procedure code does not include a professional fee.	yes W/PA	yes W/PA
92326	—	APHAKIC LENS Post operative cataract.	yes W/PA	yes W/PA
V2799	—	UNSPECIFIED PROCEDURE	yes	yes
EYE PROSTHESIS				
V2623	—	EYE PROSTHESIS Prosthetic eye, plastic, custom	yes W/PA	yes W/PA
V2624	—	POLISHING OF PROSTHESIS Polishing/resurfacing of ocular prosthesis	yes W/PA	yes W/PA
V2625	—	ENLARGEMENT of ocular prosthesis	yes W/PA	yes W/PA

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
V2626	—	REDUCTION of ocular prosthesis	yes W/PA	yes W/PA

242.120 Co-pays for Prescription of Services

11-1-09 10-1-22

Co-pays apply to the following examination codes:

View or print the procedure codes for Vision services.

S0620	S0621	92002	92004	92012	92014	99201	99202
99203	99204	99205	99211	99212	99213	99214	99215

Co-pays do not apply to codes **92340 and 92370 f**or the fitting of spectacles,

243.120 CPT Codes Payable in the Visual Care Program

12-1-10 10-1-22

The following CPT codes are payable in the Visual Care Program. Optometrists may bill procedure code **68761**for treatment of dry eye syndrome.

View or print the procedure codes for Vision services.

65205	65210	65220	65222	65430	65435	67700*	67820
67938	68020	68040	68761	68801	68810*	68811*	68815*
68840	76511	76512	76514	76516	76519	82948	92002
92004	92012	92014	92015	92020	92060	92065	92081
92082	92083	92100	92120	92130	92135	92140	92225
92226	92230	92250	92260	92283	92326***	92340	92370
96111**	99172	99173	99201	99202	99203	99204	99205
99211	99212	99213	99214	99215	99221	99222	99223
99231	99232	99233	99238	99241	99242	99243	99244
99245	99251	99252	99253	99254	99255	99281	99282
99283							

*Procedure codes with one asterisk require prior authorization when the place of service is an inpatient hospital.
**Procedure code 96111 requires prior authorization and is limited to beneficiaries under age 21 years.
***Procedure code **92326** is manually priced and requires prior authorization.

Gross visual field testing is a part of general ophthalmologic services and is not billed separately. *See the CPT manual for definitions, examples of levels of service and complete procedure code descriptions.*

243.130 Hospital Discharge Day Management

~~10-13-03~~ 10-1-22

Procedure code ~~99238~~, hospital discharge day management, may not be billed by providers on the same date of service as initial or subsequent hospital care, procedure ~~codes 99221 through 99233~~. Initial hospital care and subsequent hospital care may not be billed on the day of discharge.

View or print the procedure codes for Vision services.

243.140 Billing Instructions for Balanced Lens for Aphakia

~~4-15-05~~10-1-22

Visual Care providers must bill procedure code ~~V2799~~ (unspecified procedure) when providing balanced lenses to aphakia patients who are eligible for both Medicare and Medicaid. Medicaid providers must bill for this procedure using the CMS-1500 claim form. A copy of the lab invoice and the Medicare EOMB that reflects the denial must be attached to the claim.

View or print the procedure codes for Vision services.

243.150 Office Medical Services

~~12-1-06~~10-1-22

The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Office medical services covered in the Visual Care Program are limited to the following procedure codes:

View or print the procedure codes for Vision services.

~~92002~~	~~92004~~	~~92012~~	~~92014~~
~~99201~~	~~99202~~	~~99203~~	~~99204~~
~~99205~~	~~99211~~	~~99212~~	~~99213~~
~~99214~~	~~99215~~		

243.400 Special Billing Procedures

~~7-1-07~~10-1-22

Prosthetic providers that bill procedure codes ~~**V2623** or **V2624**~~ electronically must use an **NU** modifier. Prosthetic providers billing either of the above procedure codes on paper must also use an **NU** modifier.

View or print the procedure codes for Vision services.