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

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal No. 94**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100	10-13-03	201.100	7-1-05
201.200	10-13-03	201.200	7-1-05
201.300	10-13-03	201.300	7-1-05
201.400	10-13-03	201.400	7-1-05
226.000	10-13-03	226.000	7-1-05
244.000	10-13-03	244.000 – 244.100	7-1-05
262.000	3-15-05	262.000	7-1-05
292.110	10-13-03	292.110	7-1-05
292.430	10-13-03	292.430	7-1-05
292.510 – 292.521	10-13-03	292.510 – 292.521	7-1-05
292.524	10-13-03	292.524	7-1-05
292.540 – 292.551	10-13-03	292.540 – 292.551	7-1-05
292.570	10-13-03	292.570	7-1-05
292.590 – 292.599	10-13-03	292.590 – 292.598	7-1-05
292.675	10-13-03	292.675	7-1-05
292.682	3-15-05	292.682	7-1-05
292.700	10-13-03	292.700	7-1-05
292.770 – 292.780	10-13-03	292.770 – 292.780	7-1-05
292.822	3-15-05	292.822	7-1-05

Explanation of Updates

Sections 201.100, 201.200, 201.300 and 201.400 have been revised to add a statement informing providers that persons and entities that are excluded or debarred under state or federal law, regulation or rule are not eligible to enroll, or remain enrolled, as Medicaid providers.

Section 226.000, part A, has been revised to include certified nurse-midwife services as those that are counted toward the 12 visits per state fiscal year limit for the Physician Program. This information was inadvertently omitted from the previous provider manual update. Part B of this section has been revised to correct reference section numbers.

Section 244.000 has been revised with minor wording changes and changes in referenced section numbers.

Sections 244.100 and 244.200 are new sections added to include policy on the use of new pharmacy and therapeutic agents and radiopharmaceutical therapy.

Section 262.000 has been revised to include all procedure codes that require prior authorization as of June 1, 2005. Effective for dates of service on and after July 1, 2005, procedure code **V2501** requires modifier **UA** for billing purposes. Procedure code **92002** currently requires modifier **52**. Effective for dates of service on and after July 1, 2005, modifier **52** is invalid and modifier **UB** must be used in its place.

Section 292.110 has been revised to update the list of CPT procedure codes that are not covered by Medicaid.

Section 292.430 has been revised to delete incorrect procedure codes for the ambulatory infusion device and to include the correct procedure code and modifier.

Section 292.510 has been revised. Part B includes a change in the modifier for use with procedure codes 99221 and 99231. Effective for dates of service on and after July 1, 2005, modifier **UB** must be used in place of modifier **52**.

Section 292.521 has been revised to reflect modifier changes. Effective for dates of service on and after July 1, 2005, modifiers **UA** and **UB** must be used in place of modifiers **52** and **22** for procedure codes **99241**, **99242** and **99243**.

Section 292.524 has been revised to instruct providers to use modifier **24** when filing claims for subsequent visits within 10 days after surgery for services that are not related to the surgical procedure.

Section 292.540 has been revised to make minor wording changes for clarification purposes.

Section 292.550 has been revised to reflect changes in modifiers and add a new procedure code. Effective for dates of service on and after April 1, 2005, procedure code **58565** is covered as a family planning service. Effective for dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22** and modifier **UB** must be used in place of modifier **52** when filing claims for those procedure codes requiring modifiers.

Section 292.551 has been revised to include procedure code **87621** as a family planning-related service payable to pathologists and independent labs. Procedure code **Q0111** was inadvertently omitted from the list in a previous update. It has been added to the list.

Section 292.570 has been revised by deleting procedure codes that are no longer valid codes.

Sections 292.590 through 292.598 have been revised and reorganized for clarity. These sections include coverage information and listings of procedure codes that are covered as of June 1, 2005. Changes in modifiers effective for dates of service on and after July 1, 2005 are included.

Section 292.675 has been revised to include the correct modifier for use with procedure code **59425**. For services delivered prior to July 1, 2005, modifier **22** is to be used. For dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22**.

Section 292.682 has been revised to correct a procedure code. In the third paragraph procedure code **T0151** is incorrect and has been changed to **T1015**.

Section 292.700 has been revised. Wording has been added for clarification. Effective for dates of service on and after July 1, 2005, modifier **UB** must be used in place of modifier **52**.

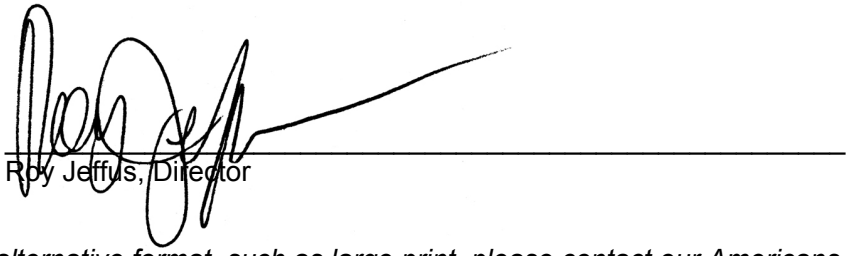
Section 292.770 has been revised to inform the provider of the correct procedure code to be used for sexual abuse examination for children under age 21 and of a modifier change.

Section 292.780 has been revised to inform the provider of correct modifiers to use for reciprocal billing arrangements and for locum tenens billing arrangements.

Section 292.822 has been revised to inform the provider of a modifier change for procedure code **A0434**.

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

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

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

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

201.100 Arkansas Medicaid Participation Requirements for Physicians 7-1-05

All physicians are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

A. A provider of physician's services must be licensed to practice in his or her state.

B. A provider of physician's services (with the exception of a pediatrician) must be enrolled in the Title XVIII (Medicare) Program.

C. A provider of physician's services must complete a provider application (form DMS-652) , Medicaid contract (form DMS-653), Request for Taxpayer Identification Number and Certification (Form W-9) and Arkansas Medicaid Primary Care Physician Managed Care Program Primary Care Physician Participation Agreement (form DMS-2608). **View or print form DMS-652, form DMS-653, Form W-9 and form DMS-2608.**

D. A copy of the following documents must accompany the application and contract:

1. The physician must submit a copy of his or her current license to practice in his or her state.

2. Out-of-state physicians must submit a copy of verification that reflects current enrollment in the Title XVIII (Medicare) Program.

E. The provider application and Medicaid contract must be approved by the Arkansas Medicaid Program as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

201.200 Arkansas Medicaid Participation Requirements for Independent Laboratories 7-1-05

All Independent Laboratories are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

A. A provider of Independent Laboratory services must be registered and have been issued a certificate and identification number under the Clinical Laboratory Improvement Amendment (CLIA) of 1988. If you need information on the Centers for Medicare and Medicaid Services (CMS) CLIA program, please contact the Arkansas Department of Health Division of Health Facility Services. **View or print the Arkansas Department of Health Division of Health Facility Services contact information.**

B. The Independent Laboratory must be certified as a Title XVIII (Medicare) provider in its home state.

C. The provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). (See Section I of this manual.)

1. A copy of the CLIA certificate and a copy of the current Title XVIII (Medicare) certification must accompany the provider application and Medicaid contract. Verification of subsequent certifications must be submitted to the Medicaid Provider Enrollment Section within 30 days of issuance.

2. Out-of-state laboratories must verification of current Title XVIII (Medicare) Program certification.

D. The Arkansas Medicaid Program must approve the provider application and Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

201.300 Arkansas Medicaid Participation Requirements for Certified Registered Nurse Anesthetist (CRNA) 7-1-05

Providers of Certified Registered Nurse Anesthetist (CRNA) services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. A provider of CRNA services must be currently licensed as a Certified Registered Nurse Anesthetist in his/her state and be nationally certified by the Council on Recertification of Nurse Anesthetists.

B. A provider of CRNA services must be certified as a Title XVIII (Medicare) CRNA provider.

C. A provider of CRNA services must complete a provider application (form DMS-652), Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). (See Section I of this manual.) **View or print form DMS-652, form DMS-653 and Form W-9.**

D. The following verifications must accompany the application and contract:

1. A copy of current state CRNA licensure and a current copy of national certification from the Council on Recertification of Nurse Anesthetists.

2. Verification of current Title XVIII (Medicare) Program certification. (Out-of-state CRNAs)

Subsequent certifications and license renewals must be submitted to Provider Enrollment within thirty days of their issue.

E. The application and contract must be approved by the Arkansas Medicaid Program as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

201.400 Arkansas Medicaid Participation Requirements for Radiation Therapy Centers 7-1-05

Providers of radiation therapy services must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must obtain and maintain a current license, certification or other proof of qualifications to operate, in conformity with the laws and rules of the state in which the provider is located.

B. The provider must be certified as a Title XVIII (Medicare) radiation therapy center in their home state.

C. The provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). (See Section I of this manual.) The following information must be submitted with the application and contract:

1. A copy of the provider's current state license or certification.
2. A copy of the provider's Title XVIII (Medicare) certification.

Subsequent certifications and license renewals must be submitted to the Arkansas Medicaid Program within thirty days of their issue.

D. The Arkansas Medicaid Program must approve the provider application and Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

226.000 Physician Services Benefit Limit 7-1-05

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

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

1. Physician services in the office, patient's home or nursing facility.
2. Rural health clinic (RHC) core services.
3. Medical services provided by a dentist.
4. Medical services furnished by an optometrist.
5. Certified nurse-midwife services.

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

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

1. Malignant neoplasm
2. HIV/AIDS
3. Renal failure

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

244.000 Covered Drugs and Immunizations 7-1-05

The Arkansas Medicaid Program provides coverage of drugs for treatment purposes and for immunizations against many diseases. Most of these are administered by injection. Appropriate procedure codes may be found in the *CPT* and *HCPCS* books and in this manual. The following types of drugs are covered.

A. Chemotherapy. (See sections 292.590 and 292.591.) No take-home drugs are covered.

B. Injections when a diagnosis of malignant neoplasm or HIV disease is indicated and oral immunosuppressive drugs. (See sections 292.590 and 292.591.) No take-home drugs are covered.

C. Desensitization (allergy) injections for recipients in the Child Health Services (EPSDT) program. (See section 292.420 of this manual for billing instructions.)

D. Immunizations, childhood immunizations and those covered for adults. (See sections 292.592 through 292.597 of this manual for special billing instructions.)

E. Other injections that are covered for specific diagnosis and/or conditions. (See sections 292.592 through 292.595.) No take-home drugs are covered.

244.100 New Pharmacy and Therapeutic Agents 7-1-05

Providers must obtain prior approval, in accordance with the following procedures, for new pharmacy and therapeutic agents.

A. Before treatment is begun, the Medical Director for the Division of Medical Services (DMS) must approve any drug not listed as covered in this provider manual or in official DMS correspondence.

   This requirement also applies to any drug with special instructions regarding coverage in the provider manual or in official DMS correspondence.

B. The Medical Director's prior approval is necessary to ensure payment of the provider's charges.

   1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.

   2. The provider will be notified by mail of the DMS Medical Director's decision. No prior authorization number is assigned if the request is approved.

Send requests for prior approval of pharmacy and therapeutic agents to the attention of the Medical Director of the Division of Medical Services. **View or print the contact information for the Arkansas Division of Medical Services Medical Director.**

Refer to section 292.598 for special billing procedures.

244.200 Radiopharmaceutical Therapy 7-1-05

Medicaid covers radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion.

Prior to beginning therapy the provider must submit the following documentation.

A. Patient history and physical report is required.

B. Drugs and therapeutic procedures previously administered must be included along with documentation that conventional therapy has failed.

C. This information must be sent to the attention of the Medical Director of the Division of Medical Services.

The provider will be notified by mail of the Medical Director's decision. If approval is received, the provider must file the claim for service with a copy of the approval letter and a copy of the invoices for the monoclonal antibody.

Refer to section 292.598 for special billing procedures.

262.000 Procedures That Require Prior Authorization 7-1-05

A. Effective April 1, 2001, procedure codes 22510, 22521 and 22522 were made payable with prior authorization. Effective March 1, 2005, these procedure codes became payable without prior authorization.

B. The following procedure codes require prior authorization:

Procedure Codes							
J7320	J7340	S0512	V5014	00170	01964	11960	11970
11971	15342	15343	15400	15831	19316	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
29866	29867	29868	30220	30400	30410	30420	30430
30435	30450	30460	30462	32851	32852	32853	32854
33140	33282	33284	33945	36470	36471	37785	37788
38240	38241	38242	42820	42821	42825	42826	42842
42844	42845	42860	42870	43257	43644	43645	43842
43843	43845	43846	43847	43848	43850	43855	43860
43865	47135	48155	48160	48554	48556	50320	50340
50360	50365	50370	50380	51925	54360	54400	54415
54416	54417	55400	57335	58150	58152	58180	58260
58262	58263	58267	58270	58280	58290	58291	58292
58293	58294	58345	58550	58552	58553	58554	58672
58673	58750	58752	59135	59840	59841	59850	59851
59852	59855	59856	59857	59866	60512	61850	61860
61862	61870	61875	61880	61885	61886	61888	63650
63655	63660	63685	63688	64573	64585	64809	64818
65710	65730	65750	65755	67900	69300	69310	69320
69714	69715	69717	69718	69930	76012	76013	87901
87903	87904	92081	92100	92326	92393	93980	93981

Procedure Code	Modifier	Description
E0779	RR	Ambulatory Infusion Device
D0140	EP	EPSDT interperiodic dental screen
L8619	EP	External Sound Processor
S0512		Daily wear specialty contact lens, per lens
V2501	Effective for dates of service on and after July 1, 2005, modifier UA is required.	Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
92002	52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	Low vision services - low vision evaluation

292.110 Non-covered CPT Procedure Codes 7-1-05

The following is a list of CPT procedure codes that are non-covered by the Arkansas Medicaid Program to providers of Physician/Independent Lab/CRNA/Radiation Therapy Center services. Some procedure codes are non-payable, but the service is payable under another procedure code. Refer to Special Billing Procedures, sections 292.000 through 292.860.

Procedure Codes							
01953	09168	09169	11900	11901	11920	11921	11922
11950	11951	11952	11954	15775	15776	15780	15781
15782	15783	15786	15787	15810	15811	15819	15820
15821	15822	15823	15824	15825	15826	15828	15829
15832	15833	15834	15835	15836	15837	15838	15839
15876	15877	15878	15879	17360	17380	21497	27193
27591	27881	28531	32850	32855	32856	33930	33933
33935	33940	33944	36415	36416	36468	36469	36540
43265	44132	44133	44135	44136	44715	44720	44721
44979	45520	46500	47133	47136	47143	47144	47145
47146	47147	48551	48552	49400	50300	50323	50325
50327	50328	50329	54401	54405	54406	54408	54410
54111	54660	54900	54901	55870	55970	55980	56805
57170	58321	58322	58323	58970	58974	58976	59426
59430	59898	65760	65771	68340	69090	69710	69711
76948	76986	78890	78891	80103	84061	87001	87003
87472	87477	87902	88000	88005	88007	88012	88014
88016	88020	88025	88027	88028	88029	88036	88037
88040	88045	88099	88188	88189	89250	89251	89252
89253	89254	89255	89256	89257	89258	89259	89260
89261	89264	90378	90379	90384	90385	90465	90466
90467	90468	90471	90472	90473	90474	90476	90477
90586	90656	90680	90693	90717	90719	90723	90725
90727	90783	90784	90788	90845	90846	90865	90875
90876	90880	90885	90887	90889	90901	90911	90918
90919	90920	90921	90935	90937	90945	90947	90989
90993	91060	92065	92070	92285	92310	92311	92312
92313	92314	92315	92316	92317	92325	92326	92330
92335	92340	92341	92342	92352	92353	92354	92355
92358	92370	92371	92390	92391	92392	92393	92395
92396	92507	92508	92510	92592	92593	92596	92597

Procedure Codes							
92605	92606	92609	93668	93701	93797	93798	94452
94453	94656	94657	94660	94662	94667	94668	94762
95078	95250	95806	96000	96001	96002	96003	96004
96110	96150	96151	96152	96153	96154	96155	97002
97004	97005	97010	97012	97014	97016	97018	97020
97022	97024	97026	97028	97032	97033	97034	97035
97036	97039	97110	97112	97113	97116	97124	97139
97140	97150	97504	97520	97530	97532	97535	97537
97542	97545	97546	97780	97781	97802	97803	97804
97810	97811	97813	97814	99000	99001	99002	99024
99026	99027	99056	99070	99071	99075	99078	99080
99090	99091	99141	99142	99239	99261	99262	99263
99315	99316	99321	99322	99323	99331	99332	99333
99344	99345	99350	99358	99359	99361	99362	99371
99372	99373	99374	99375	99377	99378	99379	99380
99381	99382	99383	99384	99385	99386	99387	99391
99392	99393	99394	99395	99396	99397	99403	99404
99411	99412	99420	99429	99431	99433	99435	99450
99455	99456	99499	99500	99501	99502	99503	99504
99505	99506	99507	99508	99509	99510	99511	99512
99539	99551	99552	99553	99554	99555	99556	99557
99558	99559	99560	99561	99562	99563	99564	99565
99566	99567	99568					

292.430 Ambulatory Infusion Device 7-1-05

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. One unit of service equals one day. A reimbursement rate has been established and represents a daily rental amount. When filing paper claims, a type of service 1 with the modifier RR. Refer to section 241.000 of this manual for coverage information and section 261.220 for prior authorization procedures.

292.510 Dialysis 7-1-05

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 level of care billed. Hemodialysis must be billed with type of service code (paper claims only) **"1".**

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. Peritoneal dialysis must be billed with type of service code (paper only) **"1"**.

Procedure Code	Required Modifier(s)	Description
90947		Class I – Acute renal failure complicated by illness, 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	52 52 Effective for dates of service on and after July 1, 2005, modifier UB must be used in place of modifier 52.	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 **90922**, **90923**, **90924** and **90925**.

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 recipient 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
6-1-04 through 6-14-04	90922	14
6-21-04 through 6-30-04	90922	11

Arkansas Medicaid also covers Iron Dextran for recipients of all ages receiving dialysis due to acute renal failure. Use procedure code **J1750** when administering in a physician's office. Units billed are equal to the milliliters administered (1 unit = 50 mg).

Procedure code **J0636** (Injection, Calcitrol, 1 mcg, ampule) is payable for eligible Medicaid recipients of all ages receiving dialysis due to acute renal failure (diagnosis codes 584 - 586).

292.520 Evaluations and Management 7-1-05

292.521 Consultations 7-1-05

When billing for office consultations when the place of service is the provider's office (POS: Paper **3**/Electronic **11**) or inpatient hospital (POS: Paper **1**/Electronic **21**), the appropriate CPT procedure codes are used according to the description of each level of service. When filing paper claims, use type of service code **"1."**

The consultation procedure codes listed below must be used when the place of service is outpatient hospital or emergency room-hospital (POS: Paper **2** or **X**, respectively/Electronic **22** or **23**, respectively) or ambulatory surgical center (POS: Paper **B**/Electronic **24**).

Procedure Code	Required Modifier(s)	Description
99241	52, 22 Effective for dates of service on and after July 1, 2005, modifiers 52, 22 are not valid. Use modifiers 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.

Procedure Code	Required Modifier(s)	Description
99242	52, 22 Effective for dates of service on and after July 1, 2005, modifiers 52, 22 are not valid. Use modifiers 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	52, 22 Effective for dates of service on and after July 1, 2005, modifiers UA, UB must be used in place of modifiers 52, 22.	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, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.	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.
99245	U1, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.	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.

292.524 Follow-Up Visits 7-1-05

Ten (10) days of postoperative care are included in the global surgery fee with the following exceptions:

A. When a modifier **"24"** is attached to the subsequent visit procedure code and the detail diagnosis is unrelated to the surgical procedure performed within the previous 10 days.

NOTE: Use of the "24" modifier must follow national guidelines.

B. When another doctor treating the patient for another condition sees the patient following surgery.

C. When an endoscopy procedure is described as diagnostic.

NOTE: If another procedure is performed and it is not described as diagnostic, the follow-up visits will not be allowed.

D. Intubation endotracheal, emergency procedure.

292.540 Factor VIII, Factor IX and Cryoprecipitate 7-1-05

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:

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. Physician claims must be billed with a type of service code **"1"** in Field 24C of the CMS-1500 claim form.

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.

292.550 Family Planning Services Program Procedure Codes 7-1-05

The following table contains Family Planning Services Program procedure codes payable to physicians. Physicians must use type of service code (paper only) **"A"** with these procedure codes. All procedure codes in this table require a family planning or sterilization diagnosis code in each claim detail.

Procedure Codes							
11975	11976	11977	55250	55450	58300	58301	58600
58605	58611	58615	58661*	58670	58671	58700*	J1055

Effective for dates of service on and after April 1, 2005, procedure code **58565** is covered as a family planning service. Procedure code **58565** includes provision of the device.

Procedure Code	**Modifier(s)**	**Description**
A4260	FP	Norplant System (Complete Kit)
J7300	FP	Supply of Intrauterine Device
S0612**	FP, TS	Annual Post-Sterilization Visit (This procedure code is unique to aid category 69, FP-W. After sterilization, this is the only service covered for individuals in aid category 69.)
36415		Routine Venipuncture for Blood Collection

Procedure Code	Modifier(s)	Description
99401	FP, 52, 22 Effective for dates of service on and after July 1, 2005, modifiers 52, 22 are not valid. Use modifiers UA, UB.	Periodic Family Planning Visit
99402	FP, 22 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.	Arkansas Dept. of Health Basic Visit
99402	FP, 22, 52 Effective for dates of service on and after July 1, 2005, modifiers 22, 52 are not valid. Use modifiers UA, UB.	Basic Family Planning Visit
99401	FP, 22, U1 Effective for dates of service on and after July 1, 2005, modifier UA must be used in place of modifier 22.	Arkansas Dept. of Health Periodic/Follow-Up Visit

* CPT codes **58661** and **58700** represent procedures to treat medical conditions as well as for elective sterilizations. When filing paper claims for either of these services for elective sterilizations, enter type of service code **"A."** When using either of these codes for treatment of a medical condition, type of service code **"2"** must be entered for the primary surgeon or type of service code **"8"** for an assistant surgeon.

When filing claims for the professional services of the outpatient clinic physician associated with a hospital, modifiers **U6**, **UA** must be used for the basic family planning visit and the periodic family planning visit. When filed on paper, these services require type of service code **"J."**

292.551 Family Planning Laboratory Procedure Codes 7-1-05

This table contains laboratory procedure codes payable in the Family Planning Services Program. They are also payable when used for purposes other than family planning. Bill

procedure codes in this table with type of service code (paper only) **"A"** when the service diagnosis indicates family planning. Refer to section 292.730 for other applicable type of service codes (paper only) for laboratory procedures.

Independent Lab CPT Codes

81000	81001	81002	81003	81025	93020
93520	83896	84703	85014	85018	85660
86592	86593	86687	86701	87075	87081
87087	87210	87390	87470	87490	87536
87590	88142*	88143*	88150***	88152	88153
88154	88155***	88164	88165	88166	88167
89300	89310	89320	Q0111		

* **Procedure codes 88142 and 88143 are limited to one unit per beneficiary per state fiscal year.**

*** **Payable only to pathologists and independent labs with type of service code (paper only) "A."**

Effective for dates of service on and after July 1, 2005, procedure code **87621** is payable as a family planning service. This code is payable only to pathologists and independent labs.

Procedure Code	**Required Modifiers**	**Description**
88302	FP	Surgical Pathology, Complete Procedure, Elective Sterilization
88302	FP, U2	Surgical Pathology, Professional Component, Elective Sterilization
88302	FP, U3	Surgical Pathology, Technical Component, Elective Sterilization

292.570 Hearing Aid Procedure Codes - Beneficiaries Under Age 21 in the Child Health Services (EPSDT) Program 7-1-05

Procedure Codes					
V5014	V5030	V5040	V5050	V5060	V5120
V5130	V5140	V5150	V5170	V5180	V5190
V5210	V5220	V5230	V5267	V5299	

292.590 Injections 7-1-05

Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the CPT coding book, in the HCPCS coding book and in this section of this manual.

Unless otherwise indicated, the procedure code for the injection includes the cost of the drug and the administration of the injection for intramuscular or subcutaneous routes.

Most of the covered drugs can be billed electronically. **However, any drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column, Field 24D, of the CMS-1500 (formerly HCFA-1500) claim form.** View a CMS-1500 sample form. Reimbursement is based on the "Red Book" drug price. If preferred, a copy of the invoice verifying the provider's cost of the drug may be attached to the Medicaid claim form.

292.591 Injections and Oral Immunosuppressive Drugs 7-1-05

A. The following procedure codes for the administration of chemotherapy agents are payable only if provided in a physician's office, place of service code: Paper **"3"** or electronic **"11."** These procedures are not payable if performed in the inpatient or outpatient hospital setting:

96400	96408	96414	96423	96545
96405	96410	96420	96425	96549
96406	96412	96422	96520	

Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim format. Supplies are included as part of the administration fee. The administration fee is not allowed when drugs are given orally.

Multiple units may be billed. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take home drugs."

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

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

This list includes drugs covered for recipients of all ages. However, when provided to individuals aged 21 or older, a diagnosis of malignant neoplasm or HIV disease is required.

Procedure Codes							
J0120	J0150		J0190	J0205	J0207	J0210	J0256
J0270	J0280	J0285	J0290	J0295	J0300	J0330	J0350
J0360	J0380	J0390	J0460	J0470	J0475	J0500	J0515
J0520	J0530	J0540	J0550	J0560	J0570	J0580	J0595*
J0600	J0610	J0620	J0630	J0640	J0670	J0690	J0694

Procedure Codes							
J0696	J0697	J0698	J0702	J0704	J0710	J0713	J0715
J0720	J0725	J0735	J0740	J0743	J0745	J0760	J0770
J0780	J0800	J0835	J0850	J0895	J0900	J0945	J0970
J1000	J1020	J1030	J1040	J1051	J1060	J1070	J1080
J1094	J1100	J1110	J1120	J1160	J1165	J1170	J1180
J1190	J1200	J1205	J1212	J1230	J1240	J1245	J1250
J1260	J1320	J1325	J1330	J1364	J1380	J1390	J1410
J1435	J1436	J1440	J1441	J1455	J1570	J1580	J1610
J1620	J1626	J1630	J1631	J1642	J1644	J1645	J1650
J1670	J1700	J1710	J1720	J1730	J1742	J1750	J1785
J1800	J1810	J1815	J1825	J1830	J1840	J1850	J1885
J1890	J1910	J1940	J1950	J1955	J1960	J1980	J1990
J2000	J2001	J2010	J2060	J2150	J2175	J2180	J2185
J2210	J2250	J2270	J2275	J2280	J2300	J2353*	J2354*
J2310	J2320	J2321	J2322	J2360	J2370	J2400	J2405
J2410	J2430	J2440	J2460	J2505*	J2510	J2515	J2540
J2550	J2560	J2590	J2597	J2650	J2670	J2675	J2680
J2690	J2700	J2710	J2720	J2725	J2730	J2760	J2765
J2783*	J2800	J2820	J2912	J2920	J2930	J2950	J2995
J3000	J3010	J3030	J3070	J3105	J3120	J3130	J3140
J3150	J3230	J3240	J3250	J3260	J3265	J3280	J3301
J3302	J3303	J3305	J3310	J3320	J3350	J3360	J3364
J3365	J3370	J3400	J3410	J3430	J3465*	J3470	J3475
J3480	J3487*	J3490*	J3520	J7190	J7191	J7192	J7194
J7197	J7310	J7501	J7504	J7505	J7506	J7507*	J7508*
J7509	J7510	J7599*	J8530	J9000	J9001	J9010	J9015
J9020	J9031	J9040	J9045	J9050	J9060	J9062	J9065
J9070	J9080	J9090	J9091	J9092	J9093	J9094	J9095
J9096	J9097	J9098*	J9100	J9110	J9120	J9130	J9140
J9150	J9165	J9170	J9178*	J9181	J9182	J9185	J9190
J9200	J9201	J9202	J9206	J9208	J9209	J9211	J9212
J9213	J9214	J9215	J9216	J9217	J9218*	J9230	J9245
J9250	J9260	J9263*	J9265	J9266	J9268	J9270	J9280
J9290	J9291	J9293	J9300	J9310	J9320	J9340	J9355
J9360	J9370	J9375	J9380	J9390	J9600	J9999*	Q0163
Q0164	Q0165	Q0166	Q0167	Q0168	Q0169	Q0170	Q0171

Procedure Codes							
Q0172	Q0173	Q0174	Q0175	Q0176	Q0177	Q0178	Q0179
Q0180	Q4075	S0115	S0187				

*Procedure code requires paper billing.

The above injections may be provided in the physician's office. Multiple units may be billed.

292.592 Other Covered Injections and Immunizations with Special Instructions 7-1-05

Physicians billing the Arkansas Medicaid Program for drugs and immunizations should bill the appropriate procedure code for the specific immunization or drug being administered.

Physicians may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 (formerly HCFA-1500) claim form. **View a DMS-694 sample form.** **View a CMS-1500 sample form.** Physicians must bill using type of service code (paper only) **"1."**

If the patient is scheduled for immunization only, reimbursement is limited to the immunization. The provider must *not* bill for an office visit but for the immunization.

The following is a list of injections with special instructions for coverage and billing.

Procedure Code	Modifier(s)	Special Instructions
J0170		The code is payable if the service is performed on an emergency basis and is provided in a physician's office.
J0150		Procedure is covered for all ages with no diagnosis restriction.
J0152		Code is payable or all ages. When administered in the office, the provider must have nursing staff available to monitor the patient's vital signs during infusion. The provider must be able to treat anaphylactic shock and provide advanced cardiac life support in the treatment area where the drug is infused.
J0585		The code is payable for individuals of all ages. Botox A is reviewed for medical necessity based on diagnosis code.
J0636		This code is payable for individuals of all ages receiving dialysis due to acute renal failure (diagnosis codes 584-586).
J0702		Coverage includes diagnosis code range 640-648.9.
J1460 J1470 J1480 J1490 J1500 J1510 J1520 J1530 J1540 J1550 J1560		Covered for individuals of all ages with no diagnosis restrictions.

Procedure Code	Modifier(s)	Special Instructions
J1563		Payable when administered to individuals of all ages with no diagnosis restrictions. Claim is manually reviewed for medical necessity, but does not require a paper claim.
J1564		Payable when administered to individuals of all ages with no diagnosis restrictions.
J1600		This code is payable for patients with a diagnosis of rheumatoid arthritis.
J1745*		Payable when administered to individuals with moderate to severe Crohn's disease, fistulizing Crohn's disease or moderate to severe active rheumatoid arthritis. See section 292.595 for billing instructions.
J2260		Payable for Medicaid beneficiaries of all ages with congestive heart failure (diagnosis codes 428-428.9) with places of service 2, X, 3 or 4 (for paper only) or 22, 23 or 11 (electronic).
J2788		Limited to one injection per pregnancy.
J2790		Limited to one injection per pregnancy.
J2910		Payable for patients with a diagnosis of rheumatoid arthritis.
J2916*		Payable for recipients aged 21 and older when there is a diagnosis of malignant neoplasm, diagnosis range 140.00-208.9, HIV disease, diagnosis code 042, or acute renal failure, diagnosis range 584-586. Paper claim is required with a statement that recipient is allergic to iron dextran.
J3420		Payable for patients with a diagnosis of pernicious anemia. Coverage includes the B-12, administration and supplies. It must not be billed in multiple units.
J3490*		This unlisted code is payable for cancidas injection 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 must be submitted with invoice. After 30 days of use, an updated medical exam and history must be submitted.
J7199		Must be billed on a paper claim form with the name of the drug, dosage and the route of administration.
J7320		Requires prior authorization. Limited to 3 injections per knee, per beneficiary, per lifetime. See section 261.240.
J9219		This procedure code is covered for males of all ages with ICD-9-CM diagnosis code 185, 198.82 or V10.46. Benefit limit is one procedure every 12 months.
Q0136 Q0137		Payable for non-ESRD use. See section 292.593 for diagnosis restrictions and special instructions.
Q0187		Payable for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Only payable with diagnosis codes 286.0, 286.1, 286.2 and 286.4.

Procedure Code	Modifier(s)	Special Instructions
Q4054 Q4055		Payable for ESRD use. See section 292.593 for diagnosis restrictions and special instructions.
Q4076		Payable for all ages with no diagnosis restrictions.
90371	U1	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.
90375* 90376*		Covered for all ages. See section 292.595 for billing instructions.
90385		Limited to one injection per pregnancy.
90581*		Payable for all ages.
90645 90646 90647 90655 90657 90658	EP, TJ	Modifiers required when administered to children under age 19. See section 292.597 for billing instructions.
90660*		Effective for dates of service on and after May 1, 2004, this procedure code is non-payable. Because of the shortage of flu vaccine, this procedure code was made payable effective October 15, 2004, through March 31, 2005, for healthy individuals of ages 5-49 and not pregnant.
90669	EP, TJ	Administration of vaccine is covered for children under age 5. See section 292.597 for billing instructions.
90675* 90676*		Covered for all ages without diagnosis restrictions. See section 292.596 for billing instructions.
90700 90702	EP, TJ	Modifiers required when administered to children under age 19. See section 292.597 for billing instructions.
90703		Payable for all ages.
90707	U1	Payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime.
90707 90712 90713 90716 90718 90720 90721 90723	EP, TJ	Modifiers required when administered to children under age 19. See section 292.597 for billing instructions.
90718		This vaccine is covered for individuals ages 19 and 20. Effective for dates of service on and after July 1, 2005, coverage of this vaccine has been extended to individuals age 21 and older.

Procedure Code	Modifier(s)	Special Instructions
90732		This code is payable for individuals aged 2 and older. 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.
90735		Payable for individuals under age 21.
90743 90744 90748	EP, TJ	Modifiers required when administered to children under age 19. See section 292.597 for billing instructions.

* Procedure code requires paper billing with applicable attachments.

292.593 Epoetin Alpha and Darbepoetin Alpha Injections 7-1-05

A. Procedure code **Q0136** – epoetin alpha (for non-ESRD use) is covered by Medicaid when provided only to patients with anemia associated with rheumatoid arthritis, sideroblastic anemia, anemia associated with multiple myeloma, anemia associated with B-cell malignancies, myelodysplastic anemia and chemotherapy induced anemia.

Effective for dates of service on and after July 1, 2004, Medicaid covers procedure code **Q0137** – darbepoetin alpha (for non-ESRD use). This procedure code is covered by Medicaid when provided only to patients with anemia associated with rheumatoid arthritis, sideroblastic anemia, anemia associated with multiple myeloma, anemia associated with B-cell malignancies, myelodysplastic anemia and chemotherapy induced anemia.

Procedure codes **Q0136** and **Q0137** are payable to the physician when provided in the office, place of service **"11."**

B. Procedure codes **Q4054** – darbepoetin alpha and **Q4055** – epoetin alpha injections are covered for beneficiaries of all ages.

Procedure codes **Q4054** and **Q4055** are covered when administered to patients with diagnosed ESRD (diagnosis range 584 – 586).

292.594 Infliximab Injection 7-1-05

The Arkansas Medicaid Program will reimburse physicians for HCPCS procedure code **J1745** with a type of service **"1"** (paper claims only). A paper claim must be submitted to EDS for manual review. The claim and any attachments must meet the following criteria.

A. The Medicaid agency's medical staff must manually review claims for infliximab injections before payment is approved.

1. Claims must be submitted to EDS on paper and accompanied by documentation of an office visit that includes a physical examination.
2. The visit must be specifically identified by its date.
3. The record of examination must verify that the patient has at least one of the following diagnoses:
   a. Moderate to severe Crohn's disease
   b. Fistulizing Crohn's disease
   c. Moderate to severe active rheumatoid arthritis

B. The documentation of the office visit and physical examination must specifically note the criteria confirming one or more of the diagnoses listed above.

C. The documentation of the dated history and physical must include the information that, as of the date of that examination, the patient's condition is such that he or she:

1. Has failed conventional therapy of at least three doses of each previous drug therapy offered (List the failed drug therapy regimens in detail),
2. Has failed all previously offered treatment regimens, of which one such treatment regimen specifically included methotrexate therapy,
3. Has fistulas present with a diagnosis that includes Crohn's disease.

292.595 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 7-1-05

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

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 administration fee.

292.596 Immunizations for Beneficiaries Under Age 21 7-1-05

The following policy applies when administering covered immunizations to Medicaid-eligible individuals under age 21.

When providers request Medicaid payment for delivery of single antigens on the same date of delivery, the component mixture procedure code must be utilized rather than billing for each single antigen separately.

If the single antigen procedure codes are billed individually for the same dates of service, the individual antigen procedure codes will be denied and the provider will be instructed to re-file using the appropriate component mixture code. When filing paper claims for vaccines administered to individuals 19 and 20 years of age, type of service code **"1"** must be used.

292.597 Vaccines for Children Program 7-1-05

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19. To enroll in the VFC Program, contact the Arkansas 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.**

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

Vaccines available through the VFC program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**. When filing paper claims, type of service code **"6"** and modifiers **EP**, **TJ**, must be entered on the claim form.

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

90645	90646	90647	90655	90657
90658	90669	90700	90702	90707
90712	90713	90716	90718	90720

90721	90723	90743	90744	90748

292.598 New Pharmacy Therapeutics and Radiopharmaceutical Therapy 7-1-05

A. New pharmacy and therapeutic agents are covered with prior approval from the Division of Medical Services Medical Director. Claims must be submitted to EDS on paper.

1. Claims must be submitted to EDS on paper.
2. Each claim must reflect, in the description of service field, the number in the treatment series of each administration for which you are billing Medicaid.
3. No prior authorization number is issued; therefore, a copy of the Medical Director's approval letter must be attached to each claim filed.

Refer to section 244.100 for coverage information and instructions for requesting prior approval.

B. Effective for dates of service on and after April 1, 2004, radiopharmaceutical therapy is covered with prior approval from the Medical Director of the Division of Medical Services. Claims must be filed using procedure code **79403**.

1. Claims must be submitted to EDS on paper.
2. A copy of the Medical Director'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.

292.675 Obstetrical Care Without Delivery 7-1-05

Obstetrical care without delivery may be billed using procedure codes **59425 (with modifier 22)** and procedure code **59426** with no modifier. Effective for dates of service on and after July 1, 2005, modifier **UA** must be used in place of modifier **22** when billing code **59425**.

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 will not be counted against the patient's physician visit benefit limit and will include routine sugar and protein analysis. Other lab tests must be billed separately and within 12 months of the date of service.

The procedure codes must be billed with a type of service code **"1"** when filing paper claims. 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 1-10-00, 2-10-00, 3-10-00, 4-10-00, 5-10-00 and 6-10-00. 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 1-10-00 through 6-10-00 and 6 units of service entered in the appropriate field. EDS 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 correct modifier for antepartum care only (4-6 visits) or **59426** for antepartum care only (7 or more visits).

292.682 Non-Emergency Services 7-1-05

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**, type of service code (paper only) **"1**,**"** 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**, type of service code (paper only) **"1**,**"** 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 recipient must be enrolled with a PCP. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

292.700 Physical and Speech Therapy Services 7-1-05

Occupational therapy services are payable only to a qualified occupational therapist. Some speech and physical therapy services may be payable to the physician, when provided. The following procedure codes must be used when filing claims for therapy services.

Procedure Code	Modifier(s)	Description	Benefit Limit
92506		Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation	30-minute unit. Maximum of 4 units per State Fiscal Year (July 1 through June 30).
97001		Evaluation for Physical Therapy	30-minute unit. Maximum of 4 units per State Fiscal Year (July 1 through June 30).
97110		Individual Physical Therapy	15-minute unit. Maximum of 4 units per day.
97110	52 Effective for dates of service on and after July 1, 2005, modifier 52 is invalid. Use modifier 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	52 Effective for dates of service on and after July 1, 2005, modifier 52 is invalid. Use modifier 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. Extension of the benefit may be requested for physical and speech therapy if medically necessary for Medicaid beneficiaries under the age of 21.

Refer to section 227.000 of this manual for more information on benefit limits.

292.770 Sexual Abuse Examination for Beneficiaries Under Age 21 7-1-05

The procedure codes **for Sexual Abuse Examination** listed in the table below are payable to physicians when provided in the physician's office or in a hospital outpatient department, emergency or non-emergency, with Place of Service: **Paper "3"/Electronic "11", Paper "X"/Electronic "23" or Paper "2"/Electronic "22"** and type of service code (paper only) **"1."** This procedure is exempt from the PCP referral requirement and is covered for recipients under the age of 21 only.

Procedure Code	Modifier	Description	Diagnosis Code
99205	U2	Sexual Abuse Examination	995.53

NOTE: One-digit POS codes are used for paper billing, while two-digit POS codes are used for electronic billing.

292.780 Substitute Physicians 7-1-05

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements regarding substitute physician billing identification:

A. Under a **reciprocal** billing arrangement (not to exceed 14 continuous days), the regular physician must identify the services as substitute physician services by entering in Field 24D in the CMS-1500 (formerly HCFA-1500) claim format a **"Q5"** modifier after the procedure code.

B. Under a **locum tenens** billing arrangement (90 continuous days or longer), the regular physician must identify the services as substitute physician services by entering in Field 24D in the CMS-1500 (formerly HCFA-1500) claim format a **"Q6"** modifier after the procedure code.

Under both the above billing arrangements, the billing (regular) physician (or medical group) must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's name and make this record available upon request. A record of the service would include the date and place of the service, the procedure code, the charge and the beneficiary involved.

These billing requirements apply to all substitute physician services including Primary Care Physician Managed Care Program services.

292.822 Billing for Renal (Kidney) Transplants 7-1-05

A. The following CPT procedure codes are payable for renal transplants with prior approval: **50320, 50340, 50360, 50365, 50370** and **50380**. 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 V59.4 (Donors, kidney) must be used for the renal donor and diagnosis code V70.8 (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.

1. 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 **22** must be used when billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code **A0434** modifier **22** 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.**

Effective for dates of service on and after July 1, 2005, modifier **22** is invalid. Providers must use modifier **UA** when filing claims for **A0434**.