Arkansas Department of Health and Human Services

Division of Medical Services

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

DATE: **February 1, 2006**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal #105**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.100	7-1-05	201.100	2-1-06
201.200	7-1-05	201.200	2-1-06
201.300	7-1-05	201.300	2-1-06
201.400	7-1-05	201.400	2-1-06
		213.110	2-1-06
221.100	10-13-03	221.100	2-1-06
223.000	10-13-03	223.000	2-1-06
225.000	10-13-03	225.000	2-1-06
227.000	10-13-03	227.000	2-1-06
229.130	2-1-05	229.130 – 229.140	2-1-06
243.000 – 243.200	10-13-03	243.000 – 243.200	2-1-06
244.000	7-1-05	244.000	2-1-06
251.100 – 251.110	10-13-03	251.100 – 251.120	2-1-06
253.000	10-13-03	253.000 – 257.000	2-1-06
262.000	12-5-05	262.000	2-1-06
		292.111	2-1-06
292.310	3-15-05	292.310	2-1-06
292.443	10-13-03	292.443	2-1-06
292.447 – 292.450	10-13-03	292.447 – 292.451	2-1-06
292.550 – 292.551	varies	292.550 – 292.551	2-1-06
292.591 – 292.592	7-1-05	292.591 – 292.592	2-1-06
292.594 – 292.596	7-1-05	292.594 – 292.596	2-1-06
292.640	10-13-03	292.640	2-1-06
292.870	3-15-05	292.870 – 292.900	2-1-06

Explanation of Updates

Sections 201.100, 201.200, 201.300 and 201.400 have been revised to include enrollment requirements for physician, independent lab, CRNA and radiation therapy center providers. A statement has been added to these sections to inform providers of an additional and final 30-day timeframe to submit verification of certification and license renewals.

Section 213.110 is a new section added to inform providers of Medicaid policy regarding physician assistant services.

Section 221.100 has been revised to clarify the period of time in which aid category 69 beneficiaries are eligible.

Section 223.000 has been reworded for clarity.

Section 225.000 has been revised to correct an error in pregnancy diagnoses that are exempt from the outpatient hospital benefit limit. Diagnosis code V23 was inadvertently included in the list of exemptions and has been deleted.

Section 227.000 has been revised to remove an unnecessary sentence about prior authorization. Prior authorization is not applicable to occupational, physical and speech therapy services.

Section 229.130 has been revised to include current administrative reconsideration of extension of benefit denial. Section 229.140 has been added to refer providers to Section I of the manual for complete information regarding administrative appeals.

Sections 243.000 through 243.200 have been revised to delete obsolete information, correct grammatical errors and clarify aid categories that are eligible for family planning services. Section 244.000 has been revised to remove a sentence and correct section number references.

Section 251.100 has been revised to include Medicaid's current policy regarding co-surgery. Information previously included in 251.100 is now in section 251.110. Information previously in section 251.110 is now included in a new section 251.120.

Section 253.000 has been revised. When the diagnosis code range is 940.0 through 949.5, application procedures do not require prior authorization.

Section 254.000 is a new section that includes previously promulgated policy regarding coverage of Enterra therapy.

Section 255.000 is a new section that includes previously promulgated policy regarding coverage of Exogen.

Section 256.000 is a new section that includes previously promulgated policy regarding coverage of gastrointestinal tract imaging with endoscopy capsule.

Section 257.000 is a new section that includes previously promulgated policy regarding coverage of physician counseling services when prescribing tobacco cessation products.

Section 262.000 has been revised to exclude procedure codes **76012** and **76013** from the list of services requiring prior authorization. These procedure codes are payable without prior authorization retroactive to March 1, 2005.

Section 292.111 is a new section added to inform providers of ICD-9-CM diagnosis codes that are not acceptable for filing claims.

Section 292.310 has been revised to remove unnecessary wording from Field 19. Service description and pertinent attachments for unlisted codes has been added to instructions for Field 24, D.

Section 292.443 has been revised to state procedure codes **90780** and **90781** are payable when provided to beneficiaries of all ages.

Section 292.447 has been updated to correct the place of service code in the example of the paper claim.

Section 292.450 has been reworded for clarity.

Section 292.451 is a new section to inform providers to use modifier 62 when filing claims for co-surgery.

Section 292.550 has been revised to clarify use of modifiers and type of service codes for family planning procedures. Procedure code J1055 has been removed from the list of CPT procedure codes and added to the list of HCPCS procedure codes. Other information has been moved within the section and reworded for readability.

Section 292.551 has been revised to add procedure codes **88174** and **88175** to the list of family planning lab procedures. These codes had been inadvertently omitted from the list of lab procedures related to family planning services. Information regarding procedure code **87621** has been relocated within this section.

Section 292.591 has been revised with wording changes for clarity. Procedure codes **J2505**, **J3465** and **J3487** have been deleted from the list of procedures in this section and moved to section 292.592.

Section 292.592 has been revised. Procedure codes **J2505**, **J3465** and **J3487** have been added to this section. Coverage and billing information for procedure codes **90375**, **90376**, **90675** and **90676** has been relocated to this section from section 292.595.

Section 292.594 has been revised to include correct billing instructions and clarify conditions for coverage of **J1745**.

Section 292.595 has been revised. Information previously located in this section has been moved to section 292.592. This section now includes coverage information and billing instructions for procedure codes **J0180** and **J1931**.

Section 292.596 has been revised. Information previously included in this section has been deleted. This section now includes more detailed billing instructions and conditions of coverage for procedure code **J3487**.

Section 292.640 has been revised to clarify multiple surgery billing procedures.

Section 292.870 has been revised to include prior authorization policy for bilaminate skin graft application procedures. Procedure codes **15342** and **15343** do not require prior authorization when the diagnosis code range is 940.0 through 949.5.

Section 292.880 is a new section that provides billing instructions for Enterra therapy services.

Section 292.890 is a new section that provides billing instructions for gastrointestinal tract imaging with endoscopy capsule.

Section 292.900 is a new section that provides billing instructions for required physician counseling services when prescribing tobacco cessation products.

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

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 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.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

201.100 Arkansas Medicaid Participation Requirements for Physicians 2-1-06

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.
3. Subsequent licensure and certifications must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional 30 and final days to comply.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

F. 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 2-1-06

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.
3. Subsequent certifications must be forwarded to Provider Enrollment within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

E. 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) 2-1-06

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)

3. Subsequent certifications and license renewals must be submitted to Provider Enrollment within 30 days of their issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

E. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

F. 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 2-1-06

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.
3. Subsequent certifications and license renewals must be submitted to the Arkansas Medicaid Program within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final 30 days to comply.

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid Provider Agreement.

E. 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.

213.110 Physician Assistant Services 2-1-06

Physician assistant services are services furnished under the direct supervision of the physician for which the physician takes full responsibility. A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon. The service is not considered to be separate from the physician's service.

221.100 Additional Family Planning Benefit Information Regarding Aid Categories 69 and 61 2-1-06

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

1. Women in the FP-W category who elect sterilization are covered for one post-sterilization visit per State fiscal year (July 1 through June 30).

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

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

223.000 Injections 2-1-06

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 292.590 through 292.599 of this manual.

225.000 Outpatient Hospital Benefit Limit 2-1-06

Medicaid-eligible recipients age 21 and older are limited to a total of 12 outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care/general or a rehabilitative hospital. This yearly limit is based on the State Fiscal Year (July 1 through June 30).

A. Outpatient hospital services include the following:

1. Non-emergency professional visits in the outpatient hospital and related physician services.
2. Outpatient hospital therapy and treatment services and related physician services.

B. Extension of benefits will be considered for patients based on medical necessity.

C. The Arkansas Medicaid Program automatically extends the outpatient hospital visit benefit for certain primary diagnoses. Those diagnoses are:

1. Malignant Neoplasm (diagnosis code range 140.0 through 208.91);
2. HIV disease (includes AIDS) (diagnosis code 042);
3. Renal failure (diagnosis code range 584 and 585) and
4. Pregnancy (diagnosis code range 630 through 677, and diagnosis codes V22.0, V22.1,and V28.0 through V28.9.

D. When a Medicaid eligible recipient's primary diagnosis is one of those listed above and the Medicaid eligible recipient has exhausted the Medicaid established benefit limit for outpatient hospital services and related physician services, the provider does not have to file for an extension of the benefit limit.

E. All outpatient hospital services for recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

F. Emergency and surgical physician services provided in an outpatient hospital setting are not benefit limited.

227.000 Physical and Speech Therapy Services 2-1-06

A. Arkansas Medicaid applies the following benefit limits for beneficiaries of all ages.

1. Evaluations for physical and speech therapy services for beneficiaries of all ages are limited to four (4) units (1 unit = 30 minutes) per State Fiscal Year (July 1 through June 30).

2. Individual and group physical therapy services for beneficiaries of all ages are limited to a maximum of four (4) 15-minute units of therapy per day. Group therapy must be provided in a group size of no more than four clients per group.

3. Arkansas Medicaid will reimburse the physician for make-up therapy sessions in the event a physical therapy session is canceled or missed. Make-up therapy sessions are covered when medically necessary and prescribed by the beneficiary's primary care physician (PCP). A new prescription, signed by the PCP, is required for each make-up therapy session.

B. Extension of the benefit may be provided for physical and speech therapy services based on medical necessity for Medicaid beneficiaries under age 21. Refer to section 229.100 of this manual for procedures for obtaining extension of benefits.

229.130 Administrative Reconsideration of Extensions of Benefits Denial 2-1-06

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and sent to AFMC within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to section 229.120.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days gives rise to a rebuttable presumption that it is not timely.

229.140 Appealing an Adverse Action 2-1-06

Please see section 190.000 *et al*. for information regarding administrative appeals.

243.000 Family Planning Services 2-1-06

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, clinics and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Physicians desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in sections 243.300 through 243.500 to Medicaid clients of childbearing age.

C. Physicians preferring not to provide family planning services may refer their patients to other providers. DHHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Division of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics

D. Complete billing instructions for family planning services are in section 292.550 of this manual.

243.100 Family Planning Services Demonstration Waiver 2-1-06

A. The Arkansas Medicaid program administers a Family Planning Services Demonstration Waiver. This waiver program extends Medicaid coverage of family planning services to women throughout Arkansas who meet the eligibility requirements for participation.

B. Family Planning Services Demonstration Waiver beneficiaries must be of childbearing age. The target population is women age 14 to age 44, but all women at risk of unintended pregnancy may apply for Family Planning Services Demonstration Waiver (FP-W) eligibility.

C. Women certified eligible under this waiver will generally remain eligible for the duration of the waiver. Loss of FP-W eligibility occurs only when an FP-W woman:

1. Moves out of the state
2. Becomes Medicaid-eligible in another Aid Category
3. Becomes pregnant or
4. Requests that her case be closed.

D. The women in the FP-W category are eligible for Medicaid coverage of *family planning services only*. The PES eligibility transaction response identifies them as eligible in Aid Category 69 (FP-W).

243.200 Family Planning Services for Women in Aid Category 61, PW-PL 2-1-06

Women in Aid Category 61, Pregnant Woman – Poverty Level (PW-PL), are eligible for all Medicaid-covered family planning services. The Medicaid Program expects, however, that many of those women who desire family planning services will apply for and obtain eligibility under the Family Planning Services Demonstration Waiver. *Beneficiaries in aid category 61 are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.*

244.000 Covered Drugs and Immunizations 2-1-06

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

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

C. Immunizations, childhood immunizations and those covered for adults. (See sections 292.592 through 292.598 of this manual for special billing instructions.)

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

251.100 Co-Surgery 2-1-06

Covered surgical procedures performed simultaneously on a Medicaid beneficiary are covered as separate procedures. Refer to section 292.451 for billing instructions.

251.110 Assistant Surgery 2-1-06

For medical payment to be made to an assistant surgeon, the physician who wishes to use an assistant surgeon must obtain prior authorization from the Arkansas Foundation for Medical Care (AFMC). Assistant surgeon services are reimbursed only when provided by a physician. See section 261.000 of this manual for prior authorization instructions. This provision applies to all surgery.

251.120 Surgical Residents 2-1-06

In order for surgeons enrolled in the Arkansas Medicaid Program to be reimbursed for services provided by a surgical resident, the surgeon must be physically present in the operating room with the resident while services are being provided.

253.000 Bilaminate Graft or Skin Substitute 2-1-06

Arkansas Medicaid covers bilaminate graft or skin substitute, known as dermal and epidermal tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements. Prior authorization is required for the product and the application procedure.

This product is designed to be used for treatment of non-infected partial and full-thickness skin ulcers due to venous insufficiency and for treatment of full-thickness neuropathic diabetic foot ulcers that extend through the dermis, but without tendon, muscle, capsule or bone exposure and which are located on the plantar, medial or lateral area of the foot (excluding the heel).

A. Indications and Documentation:

Coverage of this modality/product will be considered when all of the following conditions are satisfied and documented:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of greater than three (3) months duration and
3. Ulcers that have failed to respond to documented conservative measures of greater 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. In addition, the ulcer must be free of infection and underlying osteomyelitis and 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 following ICD-9-CM codes:

454.0

454.2

250.8 (requires a fifth-digit subclassification)

707.10

707.13

707.14

707.15

940.0 through 949.5

Prior authorization (PA) is required for the product and the application procedure. Application procedures do not require PA when the diagnosis code range is ICD-9-CM 940.0 through 949.5. Refer to section 261.120 of this manual for PA process. Refer to section 228.000 of this manual for benefit limits.

254.000 Enterra Therapy for Treatment of Gastroparesis 2-1-06

A. Effective for dates of service on and after March 1, 2005, Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages 18 through 69 with diabetic and idiopathic gastroparesis (diagnosis codes 536.3 and 250.6).

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 AFMC.

   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.

255.000 Ultrasonic Osteogenic Stimulator for Treatment of Non-Union Fractures (Exogen) 2-1-06

A. Effective for dates of service on and after March 1, 2005, Arkansas Medicaid added coverage of ultrasonic osteogenic stimulator (Exogen) for the treatment of non-union fractures for beneficiaries of all ages.

B. The prior authorization (PA) process is the same as for all durable medical equipment (DME) procedure codes that require PA. The patient's physician must prescribe the device and make a referral to the DME provider.

Prior authorization request requires documentation of the following:

1. A minimum of two sets of radiographs, separated by a minimum of 90 days, and obtained prior to starting treatment with the osteogenic stimulator.

2. Multiple views of the fracture site for each radiograph.

3. The physician's written statement that there has been no clinically significant evidence of fracture healing in the interval between the two sets of radiographs.

C. Prior authorization of the device may be approved for up to 180 days. If the need for the device extends beyond 180 days, an additional PA is required. Documentation which includes updated evaluations must be submitted with the PA request.

D. Coverage of the device does not include:

1. Non-unions of the skull, vertebrae and those tumor-related.

2. Concurrent use with other non-invasive osteogenic devices

256.000 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-06

A. Arkansas Medicaid covers wireless endoscopy capsule for evaluation of occult gastrointestinal bleeding in the anemic patient under the conditions listed blow.

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 bleeding.

3. An initial diagnosis of suspected Crohn's disease without the evidence of disease is made based on conventional diagnostic tests such as small bowel follow through and upper and lower endoscopy.

4. The evaluation indicates obscure gastrointestinal bleeding suspected of being small bowel in origin as evidenced by prior inconclusive upper and lower endoscopic studies.

B. Coverage of this procedure is limited to individuals 10 years through 20 years of age. Medical necessity requires one of the following ICD-9-CM diagnosis codes: 280.9, 578.1, 578.9 or 792.1.

C. Coverage of this procedure is limited to individuals 10 years through 20 years of age. Medical necessity requires one of the following ICD-9-CM diagnosis codes: 280.9, 578.1, 578.9 or 792.1.

D. See section 292.890 for procedure code and billing instructions.

257.000 Tobacco Cessation Products Counseling Services 2-1-06

Arkansas Medicaid covers generic Zyban (bupropion for tobacco cessation), nicotine gum or nicotine patches through the Medicaid Prescription Drug Program.

A. Physician providers may participate by prescribing covered tobacco cessation products.

1. The reimbursement to the pharmacy provider for the products is available for up to 2 ninety-three day courses of treatment within a calendar year.

2. Beneficiaries who are pregnant are allowed up to four ninety-three day courses of treatment per calendar year.

3. One course of treatment is three consecutive months.

B. Counseling by the prescriber is required for 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. A copy of the checklist is available on the Medicaid website at **www.medicaid.state.ar.us**.

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

D. Refer to section 292.900 for procedure codes and billing instructions.

262.000 Procedures That Require Prior Authorization 2-1-06

A. Retroactive to March 1, 2005, procedure codes **76012** and **76013** are payable without prior authorization.

B. The following procedure codes require prior authorization:

Procedure Codes							
J7320	J7340	S0512	S2213	V5014	00170	01964	11960
11970	11971	15342	15343	15400	15831	19318	19324
19325	19328	19330	19340	19342	19350	19355	19357
19361	19364	19366	19367	19368	19369	19370	19371
19380	20974	20975	21076	21077	21079	21080	21081
21082	21083	21084	21085	21086	21087	21088	21089
21120	21121	21122	21123	21125	21127	21137	21138
21139	21141	21142	21143	21145	21146	21147	21150
21151	21154	21155	21159	21160	21172	21175	21179
21180	21181	21182	21183	21184	21188	21193	21194
21195	21196	21198	21199	21208	21209	21244	21245
21246	21247	21248	21249	21255	21256	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	64555	64573	64585	64809
64818	65710	65730	65750	65755	67900	69300	69310
69320	69714	69715	69717	69718	69930	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	UA	Supplying and fitting Keratoconus lens (hard or gas permeable) - 1 lens
V2501	U1	Supplying and fitting of monocular lens (soft lens) - 1 lens
92002	UB	Low vision services - low vision evaluation

292.111 Non-Covered ICD-9-CM Diagnosis Codes 2-1-06

A. The following ICD-9-CM diagnosis codes are not acceptable when filing claims for services provided to beneficiaries of all ages:

V57.1, V57.2, V57.3, V72.5 and V72.6

B. The following ICD-9-CM diagnosis codes are not acceptable when filing claims for services provided to individuals under age 21:

V70.0, V70.3, V70.7, V70.9 and V72.85

292.310 Completion of CMS-1500 Claim Form 2-1-06

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.

	c. Other Accident	Check “YES” if the patient’s condition was other accident related. Check “NO” if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured’s Policy Group or FECA Number	Enter the insured’s policy group or FECA number.
	a. Insured’s Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer’s Name or School Name	Enter the insured’s employer’s name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient’s or Authorized Person’s Signature	This field is not required for Medicaid.
13.	Insured’s or Authorized Person’s Signature	This field is not required for Medicaid.
14.	Date of Current: 4. Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is required for most Physician/Independent Lab/CRNA/Radiation Therapy Center services provided by non-PCPs. Enter the referring physician’s name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.
19.	Reserved for Local Use	Not applicable.
20.	Outside Lab?	This field is not required for Medicaid
21.	Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22.	Medicaid Resubmission Code	Reserved for future use.
	Original Ref No.	Reserved for future use.
23.	Prior Authorization Number	Enter the prior authorization number, if applicable.

24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 292.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 292.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code for service delivered. Unlisted codes require a description of the service and pertinent attachments.
Modifier	Use applicable modifier.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only one diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.
K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."

25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. Do not enter any payment by the beneficiary.
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
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.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.
	GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."

292.443 Medicaid Coverage for Therapeutic Infusions (Excludes Chemotherapy) 2-1-06

Procedure codes **90780** and **90781** are payable for all ages.

292.447 Example of Proper Completion of Claim 2-1-06

The following is a cutaway section of the CMS-1500 claim form demonstrating the proper method of entering the following information:

Line No. 1 - Anesthesia for Procedure
Line No. 2 - Qualifying Circumstance

DATE (S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	Type of Service	PROCEDURES, SERVICES OR SUPPLIES (Explains Unusual Circumstances) CPT HCPCS	Modifier	DIAGNOSIS CODE	S CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
07 15 03		1	7	00560	P3	441.3	xxx xx	12				105967001
				180 min.	= 12 units							
07 15 03		1	1	99116		441.3	xxx xx	1				105967001

292.450 Assistant Surgery 2-1-06

Assistant surgeon's fees require prior authorization. For paper claims, use type of service code "**8**" with the same procedure code billed by the surgeon. When filing electronically, use modifier 80.

292.451 Co-Surgery 2-1-06

Co-surgeon billing is indicated with modifier 62. Modifier 62 must be used in accordance with CPT guidelines. Paper claims require type of service code **"2"** in addition to modifier 62. Operative reports from all physicians performing surgery during the same operative session must be attached to the claim that includes modifier 62.

292.550 Family Planning Services Program Procedure Codes 2-1-06

Family Planning Services Program procedure codes payable to physicians require a modifier "**FP**". For paper claims, physicians must use type of service code **"A"** with the modifier. 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*	

***** 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.

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 payment for the device.

Procedure Code	**Modifier(s)**	**Description**
A4260	FP	Norplant System (Complete Kit)
J1055	FP	Medroxyprogesterone acetate for contraceptive use
J7300	FP	Supply of Intrauterine Device
J7302	FP	Levonorgestrel-releasing intrauterine contraceptive system
J7303	FP	Contraceptive Supply, Hormone Containing Vaginal Ring
S0612**	FP, TS	Annual Post-Sterilization Visit After sterilization, this is the only service covered for individuals in aid category 69.)
36415		Routine Venipuncture for Blood Collection
99401	FP, UA, UB	Periodic Family Planning Visit
99401	FP, UA, U1	Arkansas Division of Health Periodic/Follow-Up Visit
99402	FP, UA	Arkansas Division of Health Basic Visit
99402	FP, UA, UB	Basic Family Planning Visit

When filing family planning claims for physician services in an outpatient clinic, use modifiers **U6**, **UA** for the basic family planning visit and the periodic family planning visit. If filing on paper, use type of service code **"J"** with the modifiers.

292.551 Family Planning Laboratory Procedure Codes 2-1-06

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	83020
83520	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
88174	88175	87621**	89300	89310	89320
Q0111					

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

** 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.

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

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

292.591 Injections and Oral Immunosuppressive Drugs 2-1-06

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 payable to the physician when furnished in the office. Multiple units may be billed, if appropriate. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs."

For coverage information regarding any 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	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	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

Procedure Codes							
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	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	J3470	J3475	J3480	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	Q0172	Q0173	Q0174	Q0175	Q0176
Q0177	Q0178	Q0179	Q0180	Q4075	S0187		

* Procedure code requires paper billing. Include the name of drug and dose given to patient. Attach invoice of the drug is not listed in the current Red Book.

292.592 Other Covered Injections and Immunizations with Special Instructions 2-1-06

Physicians may bill for immunization procedures on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 claim form. **View a DMS-694 sample form.** **View a CMS-1500 sample form.** On paper claims use type of service code "**1**."

When a patient is scheduled for immunization only, reimbursement is limited to the immunization. The provider may bill for the immunization only.

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

Procedure Code	Modifier(s)	Special Instructions
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 to provide advanced cardiac life support in the treatment area where the drug is infused.
J0170		The code is payable if the service is performed on an emergency basis and is provided in a physician's office.
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		This code is covered for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of aids, cancer or complications during pregnancy (diagnosis code range 640 – 648.9).
J0180		See section 292.595 for conditions of coverage and billing instructions.
J1100		This code is covered for beneficiaries of all ages. However, when provided to beneficiaries aged 21 and older, there must be a diagnosis of aids, cancer or complications during pregnancy (diagnosis code range 640 – 648.9).
J1460 J1470 J1480 J1490 J1500 J1510 J1520 J1530 J1540 J1550 J1560		Covered for individuals of all ages with no diagnosis restrictions.
J1563		Payable when administered to individuals of all ages with no diagnosis restrictions. Electronic claim and paper claims are manually reviewed for medical necessity, based on diagnosis code.
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*		See section 292.594 for billing instructions.
J1931		See section 292.595 for conditions of coverage and billing instructions.

Procedure Code	Modifier(s)	Special 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).
J2505*		Covered for beneficiaries of all ages for beneficiaries with diagnoses 288.0, E933.1 and a cancer diagnosis. Procedure is also covered for individuals with a cancer diagnosis and documentation of a low white count, fever and current treatment with a myelosuppressive drug.
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 beneficiaries aged 21 and older when there is a diagnosis of malignant neoplasm, diagnosis range 140.0-208.9, 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.
J3465*		Covered for non-pregnant beneficiaries aged 18 and older with a diagnosis of aids or cancer and one of the following diagnoses: 112.2, 112.3, 112.5, 112.84, 112.85, 112.9 or 117.3. Claims must be filed on paper.
J3487*		See section 292.596 for conditions of coverage and billing procedures.
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. Services require paper claims with procedure code and dosage entered infield 24.D of claim form CMS-1500 for each date of service. If date spans are used, indicate appropriate units of service. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
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.
90656	EP, TJ	Modifiers required when administered to children under age 19. Refer to section 292.598 for influenza vaccine policy.
90655		Effective October 1, 2005, this vaccine is covered for beneficiaries aged 19 and older. See section 292.598 of this manual.
90658		Vaccine is covered for beneficiaries aged 19 and older. See section 292.598 of this manual.
90660		Covered for healthy individuals ages 5-49 and not pregnant. See section 292.598 of this manual.
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. Services require paper claims with procedure code and dosage entered in field 24.D of claim form CMS-1500 for each date of service. If date spans are used, indicate appropriate units of service. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.
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.

Procedure Code	Modifier(s)	Special Instructions
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.
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.

292.594 Infliximab Injection 2-1-06

The Arkansas Medicaid Program will reimburse physicians for HCPCS procedure code **J1745** with a type of service **"1"**. The Medicaid agency's medical staff must manually review claims for infliximab injections before payment is approved.

A. Claims must be submitted to EDS on paper with any applicable attachments.

B. The claim must include one of the following diagnoses:

1. ICD-9-CM code 555.9 as the primary diagnosis **AND** a secpndary diagnosis of 565.1 **OR** 569.81;
2. ICD-9-CM code range 556.0 – 556.9:
3. ICD-9-CM code 696.0:
4. ICD-9-CM code 714.0; or
5. ICD-9-CM 724.9

292.595 Adgalsidase Beta and Laronidase Injections 2-1-06

A. Effective for dates of service on and after August 1, 2005, procedure code **J0180** – Adgalsidase beta, per 1 mg, was made payable. This procedure is covered for treatment of Fabry's disease, ICD-9-CM diagnosis code 272.7.

B. Effective for dates of service on and after August 1, 2005, procedure code **J1931** – Laronidase, per 2.9 mg, was made payable. This procedure is covered for treatment of mucopolysaccharidosis (MPS I), ICD-9-CM diagnosis code 277.5.

C. The injections may be provided in the outpatient hospital or emergency room. If the physician provides the service in the office, the following conditions apply.

1. The provider must have nursing staff available to monitor the patient's vital signs during the infusion.
2. The provider must be able to treat anaphylactic shock in the treatment area where the drugs are infused.

D. When the physician determines a Medicaid beneficiary needs the injection, he or she must obtain prior approval from the Medical Director of the Division of Medical Services before beginning therapy.

The prior approval request must include:

1. Documentation of an office visit that includes a physical examination specifically identified by its date and must note the diagnosis
2. Medical history that includes an annotated list of previous treatment protocols administered and their results
3. Statement of medical necessity, including method of diagnosis, from genetics physician

292.596 Zoledronic Acid Injection 2-1-06

A. Zoledronic acid injection, procedure code **J3487**, is payable to the physician when provided in the office for patients of all ages. However, beneficiaries aged 21 and older must have *one* of the following:

1. A diagnosis of AIDS or cancer along with diagnosis code 272.42; or
2. A diagnosis of 198.5; or

3. A diagnosis of 203.0

B. Procedure code **J3487** must be billed on paper with a type of service code **"1"** and the number of units indicated. If ICD-9-CM diagnosis criteria is used in point A above, no medical records are required.

C. Utilization Review's medical staff must manually review claims for zoledronic acid injections before payment is approved.

292.640 Multiple Surgery 2-1-06

If multiple surgical procedures are done on the same day of service, whether in the same operative session or not, each procedure should be listed in field 24.D on **one** claim form, including all appropriate modifiers. For paper claims, attach all necessary documentation to the claim. Filing all services that are performed on the same date of service on **one** claim is necessary to expedite correct payment of each procedure.

292.870 Bilaminate Graft or Skin Substitute Procedures 2-1-06

Arkansas Medicaid will reimburse physicians who furnish the manufactured viable bilaminate graft or skin substitute with prior authorization. The product is manually priced and requires paper claims using procedure code **J7340**, type of service code **"1"** (paper claims only). The manufacturer's invoice and the operative report must be attached.

Application procedures for bilaminate skin substitute, procedure codes **15342** and **15343**, require prior authorization except when the diagnosis code range is 940.0 through 949.5. The procedures are payable to the physician and must be listed separately on claims.

Surgical preparation procedures, CPT codes **15000** and **15001**, may be reimbursed when performed at the same surgical setting. These codes are to be listed separately in addition to the primary procedure and do not require PA.

292.880 Enterra Therapy for Gastroparesis 2-1-06

When filing claims for Enterra therapy for treatment of gastroparesis use procedure code **S2213** 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.

All paper claims require a type of service code "**2"** for surgery and, if necessary, type of service code "**8"** for assistant surgeon.

292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-06

For gastrointestinal tract imaging with endoscopy capsule, claims must be filed on paper with the patient's medical history and physical exam attached. Claims will be manually reviewed prior to reimbursement.

Procedure code **91110** must be used with type of service **"P"** for professional component when performed as inpatient, outpatient hospital or ambulatory surgical center. Type of service **"C"** must be used when performed in the physician's office.

292.900 Tobacco Cessation Counseling Services 2-1-06

When prescribing covered tobacco cessation products, the provider must provide counseling services when one of these products is prescribed. Procedure code **99401**, modifier **SE**, must be used for one 15-minute unit of service, and procedure code **99402**, modifier **SE**, must be used for one 30-minute unit of service.

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.