Arkansas Department
Of Health and Human Services
Division of Medical Services

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OFFICIAL NOTICE

DMS-2006-A-1 DMS-2006-G-1 DMS-2006-L-1 DMS-2006-R-1 DMS-2006-YC-1
DMS-2006-AR-1 DMS-2006-CA-1 DMS-2006-SS-1 DMS-2006-EE-1 DMS-2006-OO-1
DMS-2006-O-1 DMS-2006-Z-1 DMS-2006-DD-1 DMS-2006-QQ-1 DMS-2006-SB-1
DMS-2006-HH-1 DMS-2006-II-1 DMS-2006-KK-1 DMS-2006-YY-1 DMS-2006-U-1
DMS-2006-C-1

TO: **Health Care Provider – Ambulatory Surgical Center; ARKids First-B; Certified Nurse-Midwife; Certified Registered Nurse Anesthetists (CRNA); Child Health Management Services (CHMS); Child Health Services (EPSDT); Critical Access Hospital; End State Renal Disease; Federally Qualified Health Center (FQHC); Hospital; Independent Labs; Licensed Mental Health Practitioner (LMHP); Nurse Practitioner; Physician; Podiatrist; Radiation Therapy Center; Rehabilitative Services for Persons with Mental Illness (RSPMI); Rehabilitative Services for Youth and Children (RSYC); Rural Health Clinic (RHC); School-Based Mental Health Services; Visual and Arkansas Division of Health**

DATE: **March 15, 2006**

SUBJECT: **2006 CPT Procedure Code Conversion**

I. General Information

A review of the 2006 CPT procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT 2006 procedure codes for dates of service on and after **March 1, 2006**. Please add this information to your Medicaid provider manual until revised manual sections have been included in future updates.

Procedure codes that are identified in the CPT 2006 (Appendix B) are **non-payable** for dates of service on and after **March 1, 2006**.

II. Non-Covered 2006 CPT Procedure Codes

A. The following 2006 CPT procedure codes are non-covered for all providers.

43770	**43771**	**43772**	**43773**	**43774**
43886	**43887**	**43888**	**83037**	**90649**
90736	**90760**	**90761**	**90773**	**95251**
96102	**96103**	**96116**	**96119**	**96120**
97760	**97761**	**98960**	**98961**	**98962**
99324	**99325**	**99326**	**99327**	**99328**
99334	**99335**	**99336**	**99337**	**99339**
99340				

B. The following 2006 CPT procedure codes are not payable to outpatient hospital and ambulatory surgical centers because these services are covered by another CPT procedure code, another HCPCS code, or a revenue code.

15111	**15116**	**15131**	**15136**	**15151**
15152	**15156**	**15157**	**15171**	**15176**
15301	**15321**	**15331**	**15336**	**15341**
15361	**15366**	**15421**	**15431**	**22525**
33768	**33884**	**37185**	**37186**	**44213**
58110	**61641**	**61642**	**75956**	**75957**
75958	**75959**	**90766**	**90767**	**90768**
90774	**90775**			

C. Effective for dates of service on and after March 1, 2006, the following currently payable CPT procedure codes will become non-payable because the services are covered by another CPT procedure code or another HCPCS code for physicians, osteopaths and AHECS.

99050	**99056**	**99058**

Effective for dates of service on and after March 1, 2006, the following 2006 CPT procedure codes will be non-payable because the services are covered by another CPT procedure code or HCPCS code for physicians, osteopaths and AHECS.

90772 99051 99053 99060

D. All 2006 CPT procedure codes listed in **Category II** and **Category III** are non-covered.

III. Prior Authorization

The following 2006 CPT procedure codes require prior authorization (PA).

01966

For procedure code **01966**, the source for prior authorization is determined by the same criteria as deleted code **01964**.

IV. Diagnosis Codes

Effective for dates of service on and after March 1, 2006, diagnosis codes in range 230.0 through 238.9 are also recognized as cancer diagnosis codes.

V. Special Billing Requirements

A. The following 2006 CPT procedure codes require paper claims and supporting documentation.

01965	Procedure requires ICD-9-CM diagnosis code 631, 632, or 634.00 through 634.92
01966	Procedure requires prior authorization. For Medicaid, provider manual protocol and billing requirements must be followed the same as the deleted procedure code **01964**.
44180 **45499** **45990** **51999**	Claim requires operative report.
76376 **76377**	Claim requires medical history and physical
28890	History and physical showing treatment failure of previous conservative therapy, (i.e. NSAIDS, cortisone shots, and physical therapy)

B. The following 2006 CPT procedure codes require documentation to justify the procedure billed, except when the claim is for diagnosis codes 940.0 through 949.5.

15170 **15171** **15175** **15176**

VI. Podiatry Program

The following procedure codes are payable to podiatry providers.

15115	**15116**	**15135**	**15136**	**15155**
15156	**15157**	**15170***	**15171***	**15175***
15176*	**15320**	**15321**	**15335**	**15336**
15340	**15341**	**15365**	**15366**	**15420**
15421	**28890**	**99304**	**99305**	**99306**
99307	**99308**	**99309**	**99310**	**99318**

***** These procedure codes require documentation to justify the procedure billed, except when the claim is for diagnosis codes 940.0 through 949.5.

VII. Certified Nurse-Midwife

A. The following 2006 CPT procedure codes are payable to certified nurse-midwife providers.

90765 **90766** **90767** **90768** **90774**

90775 **90779**

B. Effective for dates of service on and after March 1, 2006, CPT procedure code **90799** is replaced by existing HCPCS procedure code **T1502**. HCPCS procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections and requires a modifier **U1** when billed electronically or on paper. Use type of service **"9"** when filing paper claims. Procedure code **T1502** must be billed when the drug is not supplied by the provider who administers the drug.

VIII. Nurse Practitioner

A. The following 2006 CPT procedure codes are payable to nurse practitioner providers.

90714	**90765**	**90766**	**90767**	**90768**
90774	**90775**	**90779**	**96401**	**96402**
96409	**96411**	**96413**	**96415**	**96416**
96417	**96521**	**96522**	**96523**	**97760**
97761	**97762**	**99304**	**99305**	**99306**
99307	**99308**	**99309**	**99310**	**99318**

B. Effective for dates of service on and after March 1, 2006, CPT procedure code **90799** is replaced by existing HCPCS procedure code **T1502**. HCPCS procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections. Procedure code **T1502** may be billed electronically or on paper. Use type of service **"N"** when filing paper claims. Procedure code **T1502** must be billed when the drug is not supplied by the provider who administers the drug.

IX. Oral Surgeon

A. The following CPT procedure codes are payable to oral surgeons effective for dates of service on and after March 1, 2006.

15040	**15115**	**15116**	**15135**	**15136**
15155	**15156**	**15157**	**15175***	**15176***
15320	**15321**	**15335**	**15336**	**15365**
15366	**15420**	**15421**	**90765**	**90766**
90767	**90768**	**90774**	**90775**	**90779**
99143	**99144**	**99145**	**99148**	**99149**
99150				

***** These procedure codes require documentation to justify the procedure billed, **except** when the claim is for diagnosis codes 940.0 through 949.5.

B. Effective for dates of service on and after March 1, 2006, CPT procedure code **90799** is replaced by existing HCPCS procedure code **T1502**. HCPCS procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections. Procedure code **T1502** may be billed electronically or on paper. Use type of service **"1"** when filing paper claims. Procedure code **T1502** must be billed when the drug is not supplied by the provider who administers the drug.

X. Outpatient Hospital

Use procedure code **90765** for IV infusion therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code 0760 (for observation), up to 8 hours maximum per day.

XI. Physician

Effective for dates of service on and after March 1, 2006, CPT procedure code **90799** is replaced by existing HCPCS procedure code **T1502**. HCPCS procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections. Procedure code **T1502** may be billed electronically or on paper. Use type of service **"1"** when filing paper claims. Procedure code **T1502** must be billed when the drug is not supplied by the provider who administers the drug.

XII. Child Health Services (EPSDT

Effective for dates of service on and after March 1, 2006, CPT procedure code **90799** is replaced by existing HCPCS procedure code **T1502**. HCPCS procedure code **T1502** is to be used for "administration only" of IM and/or subcutaneous injections. Procedure code **T1502** may be billed electronically or on paper. Use type of service **"6"** when filing paper claims. Procedure code **T1502** must be billed when the drug is not supplied by the provider who administers the drug.

XIII. Child Health Management Services (CHMS)

A. Effective for dates of service on and after March 1, 2006, the following 2006 CPT procedure codes are payable to CHMS programs.

96101 **96118** **97762**

B. Procedure code **96100** has been deleted from the 2006 CPT book and is replaced by **96101**. The following modifiers must be used with **96101** when filing claims for the CHMS services

Modifier(s)	Description
UA, UB	Psychological Testing Battery
U1, UA	Psychological Testing – children entering foster care
UA	Interpretation – children entering foster care

C. CHMS procedure code **96117** has been deleted from 2006 CPT. This procedure code has been replaced with procedure code **96118**.

D. CHMS procedure code **97703** has been deleted from 2006 CPT. It is replaced with **97762**. Procedure code **97762** will require PA as all other CHMS treatment procedures.

XIV. Rehabilitative Services for Persons with Mental Illness

A. Effective for dates of service on and after March 1, 2006, procedure code **96100** has been deleted and is non-payable. It has been replaced with 2006 CPT procedure code **96101**.

B. The modifiers listed below must be used with procedure code **96101** when filing claims for the RSPMI services described.

Modifier(s)	**Description**
HA, UA	Diagnosis – Psychological Test/Evaluation
HA, UA, UB	Diagnosis – Psychological Testing Battery

XV. School-Based Mental Health (SBMH)

Effective for dates of service on and March 1, 2006, procedure code **96100** has been deleted and is non-payable. It is replaced by procedure code **96101**. The modifiers listed below must be used with procedure code **96101** when filing claims for the SBMH services described.

Modifier(s)	**Description**
UA	Diagnosis – Psychological Test/Evaluation
UA, UB	Diagnosis – Psychological Testing Battery

XVI. Licensed Mental Health Practitioner (LMHP)

Effective for dates of service on and after March 1, 2006, procedure code **96100** has been deleted and is non-payable. It is replaced by procedure code **96101**. The modifiers listed below must be used with procedure code **96101** when filing claims for the LMHP services described. This procedure is only payable to psychologists.

Modifier(s)	**Description**
UA	Diagnosis – Psychological Test/Evaluation
UA, UB	Diagnosis – Psychological Testing Battery

XVII. Rehabilitative Services for Youth and Children (RSYC)

Effective for dates of service on and after March 1, 2006, procedure code **96100** has been deleted and is non-payable. It is replaced by procedure code **96101**. The modifiers listed below must be used with procedure code **96101** when filing claims for the RSYC services described.

Modifier(s)	**Description**
UA, UB	Psychological Testing Battery

XVIII. Additional Information

Complete descriptions of CPT 2006 procedure codes are in the CPT 2006 book. This book may be purchased from Ingenix online at **http://www.ingenixonline.com/** or by calling 1-800-464-3649.

Thank you for your participation in the Arkansas Medicaid Program.

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.

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

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

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OFFICIAL NOTICE

DMS-2006-A-2	**DMS-2006-CA-2**	**DMS-2006-DD-2**	**DMS-2006-EE-2**
DMS-2006-I-1	**DMS-2006-II-2**	**DMS-2006-J-1**	**DMS-2006-KK-2**
DMS-2006-L-2	**DMS-2006-O-2**	**DMS-2006-QQ-2**	**DMS-2006-R-2**
DMS-2006-S-1	**DMS-2006-SS-2**	**DMS-2006-T-1**	**DMS-2006-Z-2**

TO: **Health Care Providers – Ambulatory Surgical Center, Critical Access Hospital, Licensed Mental Health Professional, Podiatry, Home Health, Federally Qualified Health Centers, Prosthetics, Nurse Practitioner, Hospital, Certified Nurse Midwife, Radiation Therapy, Physician, Private Duty Nursing, Independent Lab, Transportation, End Stage Renal Disease**

DATE: **March 1, 2006**

SUBJECT: **2006 HCPCS Procedure Code Conversion**

I. **General Information**

A review of the 2006 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated HCPCS procedure codes on claims with dates of service on and after March 1, 2006.

II. **2006 HCPCS Payable Procedure Code Tables Information**

Payable procedure codes have been broken into separate tables. Tables have been created for each affected provider type (e.g.: physician, hospital etc.).

The tables are designed with nine columns of information. All columns may not be applicable for each covered program, but have been devised for ease of reference.

The first column contains the HCPCS procedure code. In some instances, the procedure code will be shown in multiples, depending on the number of types of service (TOS) for which it can be used by a provider.

II. 2006 HCPCS Payable Procedure Code Tables Information (continued)

The second column contains the type of service (TOS) code that may be used in conjunction with the procedure code. TOS codes are used with procedure codes billed on paper. **This information is provided when pertinent to billing protocol.**

The third column shows procedure codes that require manual pricing and is titled Manually Priced Y/N. A letter "Y" in the column indicates that an item is manually priced and an "N" shows that an item is not manually priced. **This information is provided when pertinent to billing protocol.** Providers should consult their program manual to review the process involved in manual pricing.

The fourth and fifth columns indicate the beginning and ending range for diagnoses for which a procedure code may be used. (e.g.: 0530 through 0549). The information is used, for example, by physicians, hospitals and others.

The sixth column indicates the diagnosis list for which a procedure code may be used. This information is used, for example, by physicians, hospitals and other provider types. Applicable lists will be shown in each provider's section.

The seventh column indicates whether a procedure undergoes medical review before payment. The column is titled "Review Y/N". The letter "Y" in the column indicates that a review is necessary; and an "N" indicates that a review is not necessary. Providers should consult their program manual to obtain the information that is needed for a review.

The eighth column shows procedure codes that require prior authorization (PA) before the service may be provided. The column is titled "PA Y/N". The letter "Y" in the column indicates that a procedure code requires prior authorization and an "N" means the code does not require prior authorization. Providers should consult their program manual to ascertain what information should be provided for the prior authorization process.

The ninth column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.

III. Diagnosis Range and Diagnosis Lists

Certain procedure codes are covered only when the primary diagnosis is covered within a diagnosis range or are on a diagnosis list.

Diagnosis List 003
ICD 9 Codes
042, 140.0 through 208.91
230.0 Through 238.9

III. Diagnosis Range and Diagnosis Lists (Continued)

Diagnosis List 027
ICD 9 Codes
20500, 20501, 20510, 20511, 20520, 20521, 20530, 20531, 20580, 20581, 20590, 20591, 2387

IV. HCPCS Procedure Codes Payable to Ambulatory Surgical Centers (ASC)

Please Note: Procedure code **S2078** described as "Laparoscopic supracervical hysterectomy (subtotal hysterectomy), with or without removal of tubes(s), with or without removal of ovary(s)" is not covered by Arkansas Medicaid.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
C9225			36320	36320		Y	N	
J1265						N	N	
J7341						N	N	

V. HCPCS Procedure Codes Payable to End Stage Renal Disease Providers (ESRD)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J0881						N	N	
J0882			584	586		N	N	
J0885						N	N	
J0886			584	586		N	N	
J1751			2809	2809		N	N	
J1752			2809	2809		N	N	

VI. HCPCS Procedure Codes Payable to Family Planning

+Family planning services require a family planning detail diagnosis code.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J7306+	A					N	N	FP

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

+Family planning services require a family planning detail diagnosis code.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J7306+	A					N	N	FP

VIII. HCPCS Procedure Codes Payable to Home Health

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A5120	H	N				N	N	
A6549	H	Y				N	Y	
J0881	H	Y				N	N	
J0882	H	N	584	586		N	N	
J0885	H	Y				N	N	
J0886	H	N	584	586		N	N	

IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes found in the hospital chart.

***** Prior approval is required before services associated with the use of procedure codes **A9542, A9543, A9544 and A9545** may be provided. To obtain prior approval, the provider must obtain a prior approval letter from the Arkansas Medicaid Medical Director and furnish the following documentation.

A. The FDA approved diagnosis clearly stated.
B. Treatment failures that the patient has previously experienced.
C. The patient's history and physical report.

****** Prior approval is required before services associated with the use of procedure code **A9547** may be provided. To obtain prior approval, the provider must:

A. Submit the patient's history and physical
B. Provide a report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic.

******* Prior approval is required for the service associated with the use of procedure code **A9555**. To obtain prior approval, the provider must:

A. Submit a history and physical

IX. **HCPCS Procedure Codes Payable to Hospitals (Continued)**

B. Submit a report on what other profusion scans have been tried and are non-diagnostic.

Protocol for galsulase (procedure code **C9224**) includes the following:

A. Galsulase requires prior approval by the Medical Director of the Division of Medical Services. Payment is not approved without approval. It is the ordering physician's responsibility to request approval for galsulase. When approval is granted, an approval letter will be sent to the physician.

B. The physician is to provide a copy of the approval letter to the hospital along with the physician's order for the drug when administered in the outpatient or emergency place of service.

C. When billing galsulase, the hospital must file a paper claim using **C9224**. A copy of the approval letter must be attached for payment to be approved. The primary detail diagnosis must be billed as 277.6.

+Procedure code **J7306** is covered for family planning. Family planning services require a family planning detail diagnosis code.

Procedure code **Q4079** requires review prior to payment.

A. This procedure code must be billed on a paper claim.

B. Submit the history and physical showing a relapse of multiple sclerosis.

Please Note: Procedure code **S2078** described as "Laparoscopic supracervical hysterectomy (subtotal hysterectomy), with or without removal of tubes(s), with or without removal of ovary(s)" is not covered by Arkansas Medicaid

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A9535			2897	2897		N	N	
A9536						N	N	
A9537						N	N	
A9538						N	N	
A9539						N	N	
A9540						N	N	
A9541						N	N	
A9542*						Y	N	
A9543*						Y	N	
A9544*						Y	N	
A9545*						Y	N	
A9547**						Y	N	
A9548						N	N	

IX. HCPCS Procedure Codes Payable to Hospitals (Continued)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A9549			1548	1548		Y	N	
A9550						N	N	
A9551						N	N	
A9552						N	N	
A9553						N	N	
A9554						N	N	
A9555***						Y	N	
A9556						N	N	
A9557			430	43491		Y	N	
A9558						N	N	
A9559			2810	2810		N	N	
A9560						N	N	
A9561						N	N	
A9562						N	N	
A9563			2384	2384		N	N	
A9564						N	N	
A9565						N	N	
A9567						N	N	
C2637						N	N	
C9224#			2776	2776		Y	N	
C9225			36320	36320		Y	N	
J0132			9654	9654		N	N	
J0133			0530	0549		N	N	
J0278					003	N	N	
J0480			V420	V420		N	N	
J0795					003	N	N	
J0881						N	N	
J0882			584	586		N	N	
J0885						N	N	
J0886			584	586		N	N	
J1162			9721	9721		N	N	
J1265						N	N	
J1451			9800	9801		N	N	
J1566						Y	N	
J1567						Y	N	
J1640			2771	2771		N	N	
J1751			2809	2809		N	N	
J1752			2809	2809		N	N	
J1945			9642	9642		N	N	
J2278					003	N	N	
J2325			4280	4289		N	N	
J2425					003	N	N	
J2503			36250	36252		N	N	
J2504						Y	N	
J2513						N	N	

IX. HCPCS Procedure Codes Payable to Hospitals (Continued)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J3285			4160	4160		N	N	
J7188			2864	2864		N	N	
J7189						Y	N	
J7306+						N	N	
J7341						N	N	
J9025					027	N	N	
J9027						N	N	
J9225			185	185		N	N	
J9264					003	N	N	
Q4079##						Y	N	
S0145			07054	07054		N	N	
S0146			07054	07054		N	N	

X. HCPCS Procedures Codes Payable to Independent Radiology

The following information is related to certain codes found within the independent radiology section below.

***** Prior approval is required before services associated with the use of procedure codes **A9542, A9543, A9544 and A9545** may be provided. To obtain prior approval, the provider must obtain a prior approval letter from the Arkansas Medicaid Medical Director and furnish the following documentation.

A. The FDA approved diagnosis clearly stated.

B. Treatment failures that the patient has previously experienced.

C. The patient's history and physical report.

****** Prior approval is required before services associated with the use of procedure code **A9547** may be provided. To obtain prior approval, the provider must:

A. Submit the patient's history and physical

B. Provide a report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic.

******* Prior approval is required for the service associated with the use of procedure code **A9555**. To obtain prior approval, the provider must:

A. Submit a history and physical

B. Submit a report on what other profusion scans have been tried and are non-diagnostic.

X. HCPCS Procedures Codes Payable to Independent Radiology (Continued)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A9535	1		2897	2897		N	N	
A9536	1					N	N	
A9537	1					N	N	
A9538	1					N	N	
A9539	1					N	N	
A9540	1					N	N	
A9541	1					N	N	
A9542*	1					Y	N	
A9543*	1					Y	N	
A9544*	1					Y	N	
A9545*	1					Y	N	
A9547**	1					Y	N	
A9548	1					N	N	
A9549	1		1548	1548		Y	N	
A9550	1					N	N	
A9551	1					N	N	
A9552	1					N	N	
A9553	1					N	N	
A9554	1					N	N	
A9555***	1					Y	N	
A9556	1					N	N	
A9557	1		430	43491		Y	N	
A9558	1					N	N	
A9559	1		2810	2810		N	N	
A9560	1					N	N	
A9561	1					N	N	
A9562	1					N	N	
A9563	1		2384	2384		N	N	
A9564	1					N	N	
A9565	1					N	N	
A9567	1					N	N	

XI. HCPCS Procedure Codes Payable to Nurse Midwives

Please Note: Bill **T1502-U1** when the drug is not supplied by the provider who administers the drug.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J1751	9		2809	2809		N	N	
J1752	9		2809	2809		N	N	
T1502	9					N	N	U1

XII. HCPCS Procedure Codes Payable to Nurse Practitioners

The following is information for procedure codes found in the chart below.

+ Procedure code **J7306** is covered for family planning. Family planning services require a family planning detail diagnosis code.

***** Bill **T1502** when the drug is not supplied by the provider who administers the drug.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J0881	N					N	N	
J0882	N		584	586		N	N	
J0885	N					N	N	
J0886	N		584	586		N	N	
J1566	N					Y	N	
J1567	N					Y	N	
J1751	N		2809	2809		N	N	
J1752	N		2809	2809		N	N	
J2278	N				003	N	N	
J7306+	A					N	N	FP
T1502*	N					N	N	

XIII. HCPCS Procedure Codes Payable to Oral Surgeons

***** Bill **T1502** when the drug is not supplied by the provider who administers the drug.

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
T1502*	1					N	N	

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

The following information is related to certain procedure codes found in the physician list.

***** Prior approval is required before services associated with the use of procedure codes **A9542, A9543, A9544 and A9545** may be provided. To obtain prior approval, the provider must obtain a prior approval letter from the Arkansas Medicaid Medical Director and furnish the following documentation.

A. The FDA approved diagnosis clearly stated.

B. Treatment failures that the patient has previously experienced.

XIV. **HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs) (Continued)**

C. The patient's history and physical report.

****** Prior approval is required before services associated with the use of procedure code **A9547** may be provided. To obtain prior approval, the provider must:

A. Submit the patient's history and physical

B. Provide a report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic.

******* Prior approval is required for the service associated with the use of procedure code **A9555**. To obtain prior approval, the provider must:

A. Submit a history and physical

B. Submit a report on what other profusion scans have been tried and are non-diagnostic.

Please Note: Protocol for galsulase (procedure code **J3490**) includes the following:

A. Physicians may bill galsulase utilizing procedure code **J3490**.

B. Galsulase injections may be provided in the outpatient hospital, emergency room, or office place of service.

If provided 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.

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

D. The prior approval request must include:

1. Documentation of an office visit in 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 by a Genetics physician, which must include the method of diagnosis.

E. All approval letters are issued by the Medical Director's office.

XIV. **HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs) (Continued)**

F. If galsulase is to be provided in the outpatient hospital or emergency room, it is the ordering physician's responsibility to request approval for galsulase.

1. When approval is granted, an approval letter must be sent to the physician.
2. The physician must provide a copy of the approval letter to the hospital along with the physician's order for the drug when administered in the outpatient or emergency place of service.

G. When billing galsulase, the physician must file a paper claim using **J3490**. A copy of the approval letter must be attached for payment to be approved. The primary detail diagnosis must be billed as 277.6.

+Procedure code **J7306** is covered for family planning. Family planning services require a family planning detail diagnosis code.

Procedure code **Q4079** requires review prior to payment.

A. This procedure code must be billed on a paper claim.

B. Submit the history and physical showing a relapse of multiple sclerosis.

***** Bill **T1502** when the drug is <u>not</u> supplied by the provider who administers the drug.

***** Bill **T1502 EP** when the drug is <u>not</u> supplied by the provider who administers the drug.

Please Note: Procedure code **S2078** described as "Laparoscopic supracervical hysterectomy (subtotal hysterectomy), with or without removal of tubes(s), with or without removal of ovary(s)" is not covered by Arkansas

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A9535	1		2897	2897		N	N	
A9536	1					N	N	
A9537	1					N	N	
A9538	1					N	N	
A9539	1					N	N	
A9540	1					N	N	
A9541	1					N	N	
A9542*	1					Y*	N	
A9543*	1					Y*	N	
A9544*	1					Y*	N	

XIV. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs) (Continued)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A9545*	1					Y*	N	
A9547**	1					Y**	N	
A9548	1					N	N	
A9549	1		1548	1548		Y	N	
A9550	1					N	N	
A9551	1					N	N	
A9552	1					N	N	
A9553	1					N	N	
A9554	1					N	N	
A9555	1					Y***	N	
A9556	1					N	N	
A9557	1		430	43491		Y	N	
A9558	1					N	N	
A9559	1		2810	2810		N	N	
A9560	1					N	N	
A9561	1					N	N	
A9562	1					N	N	
A9563	1		2384	2384		N	N	
A9564	1					N	N	
A9565	1					N	N	
A9567	1					N	N	
J0133	1		0530	0549		N	N	
J0278	1				003	N	N	
J0480	1		V420	V420		N	N	
J0795	1				003	N	N	
J0881	1					N	N	
J0882	1		584	586		N	N	
J0885	1					N	N	
J0886	1		584	586		N	N	
J1566	1					Y	N	
J1567	1					Y	N	
J1640	1		2771	2771		N	N	
J1751	1		2809	2809		N	N	
J1752	1		2809	2809		N	N	
J2278	1				003	N	N	
J2425	1				003	N	N	
J2503	1		36250	36252		N	N	
J2504	1					Y	N	
J2513	1					N	N	
J7306+	A					N	N	FP
J7341	1					N	N	
J9025	1				027	N	N	
J9225	1		185	185		N	N	
J9264	1				003	N	N	

XIV. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs) (Continued)

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
Q4079##	1					Y	N	
S0145	1		07054	07054		N	N	
S0146	1		07054	07054		N	N	
T1502*	1					N	N	
T1502*	6					N	N	EP

XV. HCPCS Procedure Codes Payable to Podiatrists

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J7341	4					N	N	

XVI. HCPCS Procedure Codes Payable to Private Duty Nursing

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A6549	S	Y				N	N	
A6549	1	Y				N	Y	

XVII. HCPCS Procedure Codes Payable to Prosthetics

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
A5120	H	N				N	N	
A5512	H	N	25000	25193		N	N	
A5513	H	N	25000	25193		N	N	
A6513	H	Y				N	Y	
A6530	H	Y				N	N	
A6530	6	Y				N	N	
A6549	H	Y				N	Y	
E0705	H	N				N	Y	
E0705	6	N				N	N	EP
E0911	H	N				N	N	
E0911	6	N				N	N	EP
E0911	I	N				N	N	
E2207	H	N				N	N	

XVII. **HCPCS Procedure Codes Payable to Prosthetics (Continued)**

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
E2207	6	N				N	N	EP
E2208	H	N				N	N	
E2208	6	N				N	N	EP
E2209	H	N				N	N	
E2209	6	N				N	N	EP
E2210	H	N				N	N	
E2210	6	N				N	N	EP
E2211	H	N				N	N	
E2211	6	N				N	N	EP
E2212	H	N				N	N	
E2212	6	N				N	N	EP
E2213	H	N				N	N	
E2213	6	N				N	N	EP
E2214	H	N				N	N	
E2214	6	N				N	N	EP
E2215	H	N				N	N	
E2215	6	N				N	N	EP
E2220	H	N				N	N	
E2220	6	N				N	N	EP
E2221	H	N				N	N	
E2221	6	N				N	N	EP
E2226	H	N				N	N	
E2226	6	N				N	N	EP
E2372	H	N				N	N	
E2372	6	N				N	N	EP
L0621	H	N				N	N	
L0621	6	N				N	N	EP
L0622	H	N				N	N	
L0622	6	N				N	N	EP
L0623	H	N				N	N	
L0623	6	N				N	N	EP
L0624	H	Y				N	N	
L0624	6	Y				N	N	EP
L0625	H	N				N	N	
L0625	6	N				N	N	EP
L0626	H	N				N	N	
L0626	6	N				N	N	EP
L0627	H	N				N	N	
L0627	6	N				N	N	EP
L0628	H	N				N	N	

XVII. **HCPCS Procedure Codes Payable to Prosthetics (Continued)**

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
L0628	6	N				N	N	EP
L0629	H	Y				N	N	
L0629	6	Y				N	N	EP
L0630	H	N				N	N	
L0630	6	N				N	N	EP
L0631	H	N				N	N	
L0631	6	N				N	N	EP
L0632	H	Y				N	N	
L0632	6	Y				N	N	EP
L0633	H	N				N	N	
L0633	6	N				N	N	EP
L0634	H	Y				N	N	
L0634	6	Y				N	N	EP
L0635	H	N				N	N	
L0635	6	N				N	N	EP
L0636	H	N				N	N	
L0636	6	N				N	N	EP
L0637	H	N				N	N	
L0637	6	N				N	N	EP
L0638	H	N				N	N	
L0638	6	N				N	N	EP
L0639	H	N				N	N	
L0639	6	N				N	N	EP
L0640	H	N				N	N	
L0640	6	N				N	N	EP
L0859	H	N				N	Y	
L0859	6	N				N	N	EP

Please Note: Effective for dates of service on and after March 1, 2006, a change in treatment of services associated with the procedure codes listed below will be in effect. Prior authorization will no longer be required when billing for the following items, however, the beneficiary's medical condition must fall within the diagnosis range of 250.00 and 251.93.

A5500	A5501	A5503	A5504	A5505	A5506	A5510

XVIII. **HCPCCS Procedure Codes Payable to Transportation**

2006 Codes	TOS	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier
J1265	E					N	N	

XIX. **Miscellaneous Changes**

Several previously payable HCPCS or local codes have been deleted in the 2006 HCPCS conversion. The table below lists the deleted HCPCS or local code, any replacement code and the program(s) affected.

Replacement Code	Deleted Code	Program(s) Affected
A5120	A5119	Home Health, Prosthetics
A5512	A5509	Prosthetics
A5513	A5511	Prosthetics
A6530	L8100	Prosthetics
A6549	L8239	Home Health, Prosthetics
E0705	E0972	Prosthetics
E2207	K0102	Prosthetics
E2208	K0104	Prosthetics
E2209	K0106	Prosthetics
E2210	K0452	Prosthetics
E2211	K0067	Prosthetics
E2212	K0068	Prosthetics
E2213	K0064	Prosthetics
E2214	K0074	Prosthetics
E2215	K0078	Prosthetics
E2220	K0066	Prosthetics
E2221	K0076	Prosthetics
E2372	Z1663	Prosthetics
J1751	J1750	AHEC, ESRD, Hospital, Nurse Midwife, Nurse Practitioner, Physician
J1752	J1750	AHEC, ESRD, Hospital, Nurse Midwife, Nurse Practitioner, Physician
J1945	Q2021	Hospital
J7306	A4260	Physician, Family Planning, FQHC, Nurse Practitioner, AHEC, Hospital

Replacement Code	Deleted Code	Program(s) Affected
L0621	K0630	Prosthetics
L0622	K0631	Prosthetics
L0623	K0632	Prosthetics
L0624	K0633	Prosthetics
L0625	K0634	Prosthetics
L0626	K0635	Prosthetics
L0627	K0636	Prosthetics
L0628	K0637	Prosthetics
L0629	K0638	Prosthetics
L0630	K0639	Prosthetics
L0631	K0640	Prosthetics
L0632	K0641	Prosthetics
L0633	K0642	Prosthetics
L0634	K0643	Prosthetics
L0635	K0644	Prosthetics
L0636	K0645	Prosthetics
L0637	K0646	Prosthetics
L0638	K0647	Prosthetics
L0639	K0648	Prosthetics
L0640	K0649	Prosthetics
L0859	L0860	Prosthetics

The following procedure codes are new non-covered codes that replace previously non-covered codes.

Replacement	Deleted	Replacement	Deleted	Replacement	Deleted
A6531	L8110	A6539	L8190	E2219	K0075
A6532	L8120	A6540	L8195	J1675	Q2020
A6533	L8130	A6541	L8200	L0491	K0618
A6534	L8140	A6542	L8210	L0492	K0619
A6535	L8150	A6543	L8220	L5858	K0670
A6536	L8160	A6544	L8230	L8623	K0731
A6537	L8170	E0170	E0169	L8624	K0732
A6538	L8180	E0171	E0169		

XX. **Non-Covered HCPCS Procedure Codes**

The following procedure codes are not covered by Arkansas Medicaid.

A0998	A9698	G8011	G8036	G8082	G8152	G9041	G9071	G9096	G9121	L2034	L5858	L8688	Q0503
A4218	C9723	G8012	G8037	G8093	G8153	G9042	G9072	G9097	G9122	L2387	L5971	L8689	Q0504
A4233	C9724	G8013	G8038	G8094	G8154	G9043	G9073	G9098	G9123	L3671	L6621	Q0480	Q0505
A4234	C9725	G8014	G8039	G8099	G8155	G9044	G9074	G9099	G9124	L3672	L6677	Q0481	Q0510
A4235	E0170	G8015	G8040	G8100	G8156	G9050	G9075	G9100	G9125	L3673	L6883	Q0482	Q0511
A4236	E0171	G8016	G8041	G8103	G8157	G9051	G9076	G9101	G9126	L3702	L6884	Q0483	Q0512
A4363	E0172	G8017	G8051	G8104	G8158	G9052	G9077	G9102	G9127	L3763	L6885	Q0484	Q0513
A6531	E0485	G8018	G8052	G8106	G8159	G9053	G9078	G9103	G9128	L3764	L7400	Q0485	Q0514
A6532	E0486	G8019	G8053	G8107	G8160	G9054	G9079	G9104	G9129	L3765	L7401	Q0486	Q0515
A6533	E2216	G8020	G8054	G8108	G8161	G9055	G9080	G9105	G9130	L3766	L7402	Q0487	Q4080
A6534	E2217	G8021	G8055	G8109	G8162	G9056	G9081	G9106	J0365	L3905	L7403	Q0488	S0142
A6535	E2218	G8022	G8056	G8110	G8163	G9057	G9082	G9107	J1430	L3913	L7404	Q0489	S0143
A6536	E2219	G8023	G8057	G8111	G8164	G9058	G9083	G9108	J1675	L3919	L7405	Q0490	S0197
A6537	E2222	G8024	G8058	G8112	G8165	G9059	G9084	G9109	J3355	L3921	L7600	Q0491	S0265
A6538	E2223	G8025	G8059	G8113	G8166	G9060	G9085	G9110	J7620	L3933	L8609	Q0492	S0595
A6539	E2224	G8026	G8060	G8114	G8167	G9061	G9086	G9111	J7627	L3935	L8623	Q0493	**S2078**
A6540	E2225	G8027	G8061	G8115	G8170	G9062	G9087	G9112	J7640	L3961	L8624	Q0494	S3005
A6541	E2371	G8028	G8062	G8116	G8171	G9063	G9088	G9113	J8498	L3967	L8680	Q0495	S8270
A6542	G0333	G8029	G8075	G8117	G8172	G9064	G9089	G9114	J8515	L3971	L8681	Q0496	S8940
A6543	G0372	G8030	G8076	G8126	G8182	G9065	G9090	G9115	J8540	L3973	L8682	Q0497	V2788
A6544	G8006	G8031	G8077	G8127	G8183	G9066	G9091	G9116	J8597	L3975	L8683	Q0498	
A9281	G8007	G8032	G8078	G8128	G8184	G9067	G9092	G9117	J9175	L3976	L8684	Q0499	
A9282	G8008	G8033	G8079	G8129	G8185	G9068	G9093	G9118	K0730	L3977	L8685	Q0500	
A9546	G8009	G8034	G8080	G8130	G8186	G9069	G9094	G9119	L0491	L3978	L8686	Q0501	
A9566	G8010	G8035	G8081	G8131	G9033	G9070	G9095	G9120	L0492	L5703	L8687	Q0502	

XX. Non-Covered HCPCS Procedure Codes (Continued)

Please Note: Procedure code **S2078** described as "Laparoscopic supracervical hysterectomy (subtotal hysterectomy), with or without removal of tubes(s), with or without removal of ovary(s)" is not covered by Arkansas

XXI. Non-Covered HCPCS with Elements of CPT or Other Procedure Codes

The following 2005 HCPCS procedure codes are not payable because these services are covered by another CPT procedure code, another HCPCS procedure code or by a revenue code.

A4411	A9275	E0762	E1812	G0376	J2850	Q9946	Q9950	Q9954	Q9958	Q9962	S0198	S2075	S2114
A4412	B4185	E0764	G0235	G0378	J3471	Q9947	Q9951	Q9955	Q9959	Q9963	S0613	S2076	S2117
A4604	E0641	E0912	G0332	G0379	J3472	Q9948	Q9952	Q9956	Q9960	Q9964	S0625	S2077	S2900
A6457	E0642	E1392	G0375	J2805	Q9945	Q9949	Q9953	Q9957	Q9961	S0133	S2068	S2079	S3626
													S3854

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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.

Roy Jeffus, Director