Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – ARKids First**

DATE: **December 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #47**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
222.300	8-1-06	222.300	12-1-06
222.310	9-1-06	222.310	12-1-06
240.200	11-1-06	240.200	12-1-06
262.110	8-1-06	262.110	12-1-06

Explanation of Updates

Effective for dates of service on and after December 1, 2006, the Arkansas Foundation for Medical Care, Inc. (AFMC) will provide medically necessary determinations on prior authorization requests for some medical supplies, including supplies for maintenance of the drug infusion catheter, supplies for the external drug infusion pump and Jobst stocking and durable medical equipment, excluding wheelchairs, wheelchair seating systems and wheelchair repair.

Providers must submit requests for prior authorization to AFMC on form AFMC-103, titled "Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Components."

Section 222.300 has been revised to advise that ARKids First B participants may now have one periodic dental screening, including bite-wings, and prophylaxis/fluoride treatments every six (6) months plus one day rather than once per state fiscal year.

Section 222.310 has been revised to remove language regarding one dental screen per state fiscal year.

Section 240.200 has been revised to change the language regarding the Prior Authorization Process to match the language in related manuals.

Section 262.110 has been revised at ***NOTE:** to include A4221 and A4222 as medical supply procedure codes requiring prior authorization using form AFMC-103.

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 (TDD only).

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

TOC not required

222.300 Dental Services Benefit Limit 12-1-06

Dental services for ARKids First-B participants are limited to one periodic dental exam, bite-wings, and prophylaxis/fluoride treatments every six (6) months plus one (1) day. See section 262.100 to view the procedure code for periodic dental screening exams. Scalings are limited to once per State Fiscal Year (SFY).

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

Procedure Code	Description
D1110	Prophylaxis – adult (ages 10-20)
D1120	Prophylaxis – child (ages 0-9)
D1201	Topical application of fluoride (including prophylaxis) - child (ages 0-9)
D1205	Topical application of fluoride (including prophylaxis) - adult (ages 10-18)

Refer to Section II of the Dental Provider Manual for a complete listing of covered dental services. **Orthodontia Services are not covered for ARKids First-B participants.**

Procedure codes for treatment services that are not shown as payable may be requested on treatment plans subject to review and approval by the Division of Medical Services dental consultants if such treatment is deemed medically necessary.

222.310 Preventive Dental Screens 12-1-06

A. Initial/Periodic Preventive Dental Screens

Procedure code **D0120** must be billed for an initial/periodic preventive dental screening**.**

B. Interperiodic Preventive Dental Screens

ARKids B participants may receive interperiodic preventive dental screening. There is no limit on this service. However, prior authorization must be obtained in order to receive reimbursement. See Section 240.200 for prior authorization information.

Procedure code **D0140** must be billed for an interperiodic preventive dental screen. This service requires prior authorization.

240.200 Prior Authorization (PA) Process for Interperiodic Preventive Dental Screens 12-1-06

Prior authorization for procedure code D0140, Interperiodic Dental Screening Exam, must be requested on the ADA claim form or online with a brief narrative through the Prior Authorization Manipulation (PAM) software. **View or print the Department of Health and Human Services Medicaid Dental Unit address.**

Refer to Section 222.310 of this manual for coverage and billing information.

262.110 Medical Supplies Procedure Codes 12-1-06

The following medical supplies procedure codes may be billed by Medicaid-enrolled Home Health and Prosthetics providers for ARKids First-B participants. **Type of service (TOS) codes are used only when billing on paper.**

A4206	A4221	A4222	A4253 U1	A4256
A4259 U2	A4265	A4310	A4311	A4312
A4313	A4314	A4315	A4316	A4320
A4322	A4326	A4327	A4328	A4330
A4338	A4340	A4344	A4346	A4348
A4351	A4352	A4354	A4355	A4356
A4357	A4358	A4359	A4361	A4362
A4364	A4367	A4369	A4371	A4397
A4398	A4399	A4400	A4402	A4404
A4405	A4406	A4450	A4452	A4455
A4558	A4561	A4562	A4623	A4624
A4625	A4626	A4628	A4629	A4772
A4927	A5051	A5052	A5053	A5054
A5055	A5061	A5062	A5063	A5071
A5072	A5073	A5081	A5082	A5093
A5102	A5105	A5112	A5113	A5114
A5120	A5121	A5122	A5126	A5131
A6154	A6234	A6241	A6242	A6248
A7520	B4086	E0776		

Procedure Code	Required Modifier(s)	TOS Code	Description
A6257	—		Transparent film, each (16 square inches or less)
A6258	—		Transparent film, each (more than 16, but less than 48 square inches)
A6259	—		Transparent film, each (more than 48 square inches)
A6216 A6219 A6228	—		Gauze pads medicated or non-medicated, each (16 square inches or less)
A6217 A6220 A6229	—		Gauze pads medicated or non-medicated, each (more than 16, but less than 48 square inches)

Procedure Code	Required Modifier(s)	TOS Code	Description
A6403			
A6204 A6218 A6221 A6230	—		Gauze pads medicated or non-medicated, each (more than 48 square inches)
A6441 A6446	—		Gauze, non-elastic, per roll (1 linear yard)
A6242 A6245	—		Hydrogel dressing, each (16 square inches or less)
A6243 A6246	—		Hydrogel dressing, each (more than 16, but less than 48 square inches)
A6244 A6247	—		Hydrogel dressing, each (more than 48 square inches)
A6248	—		Hydrogel dressing, each (1 ounce)
A6234 A6237	—		Hydrocolloid dressing, each (16 square inches or less)
A6235 A6238	—		Hydrocolloid dressing, each (more than 16, but less than 48 square inches)
A6238	U1		Hydrocolloid dressing, each (more than 48 square inches)
A6196	—		Alginate dressing, each (16 square inches or less)
A6197	—		Alginate dressing, each (more than 16, but less than 48 square inches)
A6198	—		Alginate dressing, each (more than 48 square inches)
A6197	—		Alginate dressing, each (1 linear yard)
A6209 A6212	—		Foam dressing, each (16 square inches or less)
A6210 A6213	—		Foam dressing, each (more than 16, but less than 48 square inches)
A6211	—		Foam dressing, each (more than 48 square inches)
A6200 A6203	—		Composite dressing, each (16 square inches or less)
A6201 A6204	—		Composite dressing, each (more than 16, but less than 48 square inches)
A6202 A6205	—		Composite dressing, each (more than 48 square inches)
A4253	—		Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4353	—		Urinary intermittent catheter with insertion supplies

Procedure Code	Required Modifier(s)	TOS Code	Description
A4394	—		Ostomy deodorant, all types, per ounce
A4365	—		Adhesive remover wipes, any type, per 50
A4368	—		Ostomy filters, any type, each
A6449 A6452	—		Gauze elastic, all types, per roll (linear yard)
A4483	—		Moisture exchange/agreer, disposable, for use with invasive mech
B4100	—	H	Food thickener, administered orally, per oz.
A6549*	—		Stocking (Jobst)

***NOTE: A4221, A4222 and A6549 must be prior authorized. Form AFMC-103 must be used for the request for prior authorization. View or print form AFMC-103 and instructions for completion.**

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

The following procedure code must be utilized when billing for Pedia-Pop. Reimbursement for this product is provider's cost plus ten percent. Pedia-Pop is only for oral consumption, and only in frozen form.

Z2487 Pedia-Pop 1 unit = 1 box Maximum = 2 units per date of service

NOTE: Pedia-Pop must be billed on paper.