ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
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TO: **Arkansas Medicaid Health Care Provider – Ambulatory Surgical Center**

DATE: **November 1, 2007**

SUBJECT: **Provider Manual Update Transmittal #90**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	blank
201.100	6-1-06	201.100	11-1-07
—	—	201.200	11-1-07
—	—	201.300	11-1-07
—	—	201.400	11-1-07
202.000	10-13-03	202.000	11-1-07
211.000	10-13-03	210.100	11-1-07
212.000	10-13-03	210.200	11-1-07
—	—	210.210	blank
—	—	210.211	11-1-07
—	—	210.212	11-1-07
—	—	210.213	11-1-07
—	—	210.214	11-1-07
—	—	210.215	11-1-07
—	—	210.216	11-1-07
213.000	blank	—	—
213.100	10-13-03	—	—
213.200	10-13-03	—	—
213.210	10-13-03	—	—
216.600	10-13-03	216.600	11-1-07
216.700	10-13-03	216.700	11-1-07
216.800	6-1-06	216.800	11-1-07
—	—	216.810	11-1-07
—	—	216.820	11-1-07
—	—	216.830	11-1-07
230.100	5-1-07	230.100	11-1-07

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
242.000	5-1-07	242.000	blank
242.100	5-1-07	242.100	blank
242.110	5-1-07	242.110	11-1-07
242.120	5-1-07	242.120	11-1-07
242.140	5-1-07	242.140	11-1-07
—	—	242.160	11-1-07

Explanation of Updates

Section 201.000: This section heading has been amended to include to add the provider type. Additionally, the rules formerly comprising this section have been categorized and moved to sections appropriate to their categories. Section 201.100: This section sets forth participation requirements for in-state Ambulatory Surgical Centers (ASCs) only.

Section 201.200: This new section sets forth Medicaid participation requirements for ASCs in approved bordering-state trade area cities. Additionally, it identifies the approved bordering-state trade area cities.

Section 201.300: This new section explains that ASCs in bordering states that are not in approved trade area cities may not enroll in Arkansas Medicaid.

Section 201.400: This new section explains that ASCs in states not bordering Arkansas may not enroll in Arkansas Medicaid.

Section 202.000: This section is included to assemble in one section Arkansas Medicaid's general rules regarding providers' records.

Section 210.100: This section replaces former section 211.000. It provides a brief, general description of the Medicaid Program and refers providers to Arkansas Medicaid's definition of "medical necessity."

Section 210.200: This section replaces former sections 212.000, 213.000 and 213.100. It combines, revises and updates definitions and rules regarding ASC facility services.

Section 210.210: This is the heading of a new section.

Section 210.211: This section lists services that are not included in Arkansas Medicaid's definition of global ASC facility services.

Section 210.212: This section describes Medicaid's coverage of intraocular lenses provided by ASCs.

Section 210.213 This information regarding physician's services is not new; the section is merely renumbered.

Section 210.214: The information in this section was formerly in a different section. The text has been formatted and revised for clarification.

Section 216.600: This is a new heading. The rule formerly under this section number has been renumbered 216.601.

Section 216.601: This new section contains the rule formerly numbered 216.600.

Section 216.602: This section is included to correct an oversight. Section 234.000 explains ASC reimbursement for extracorporeal shockwave lithotripsy (ESWL), but the manual previously has contained no description of ESWL coverage in an ASC.

Section 216.603: This section is a rule previously omitted from this manual.

Section 216.700: This section has been reformatted and a reference to oral surgeons has been added for clarification.

Section 216.800: Former section 216.800 now comprises four sections. This new section 216.800 contains general information and rules regarding hyperbaric oxygen therapy (HBO_2).

Section 216.810: This new section provides instructions for obtaining prior approval for HBO_2 treatments.

Section 216.820: This new section is a portion of former section 216.800.

Section 216.830: This new section is a portion of former section 216.800.

Section 221.000: This section is included to correct a sentence in part C.

Section 230.100: This section is included to revise a cross-reference, delete redundant information and to add information regarding covered non-surgical procedures and procedures not grouped for reimbursement purposes.

Section 242.000: This section heading is included to delete the revised date in accordance with recently revised internal practices and procedures.

Section 242.100: This section heading is included to delete the revised date in accordance with recently revised internal practices and procedures.

Section 242.110: This section is included to correct the revenue codes for outpatient dental surgery and to instruct providers how to choose the appropriate revenue code for an outpatient dental surgery.

Section 242.120: This section has been included to correct the rule regarding occurrence codes on claims for burn dressing changes.

Section 242.140: This section provides billing instructions for hyperbaric oxygen therapy.

Section 242.160: This section provides billing instructions for New Technology Intraocular Lenses.

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, official notices, remittance advice (RA) messages and proposed rules for public comment 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

TOC required

201.000 Arkansas Medicaid Participation Requirements for Ambulatory Surgical Centers (ASCs[d1])

201.100 Participation Requirements for ASCs in Arkansas 11-1-07

Ambulatory Surgical Centers (ASCs) in Arkansas that meet the following conditions are eligible to participate in the Arkansas Medicaid Program.

A. An ASC in Arkansas must be licensed by the Arkansas Department of Health as an Ambulatory Surgical Center.

1. A copy of the ASC's current license must accompany the provider application and Medicaid contract.
2. An enrolled ASC must forward to Provider Enrollment a copy of each subsequent license within 30 days of the license's issuance.
3. Failure to maintain proof of licensure will result in termination of an ASC provider's Arkansas Medicaid contract.

B. An ASC must have CMS approval (following certification and recommendation by the State Survey Agency) to participate as a Title XVIII (Medicare) provider.

1. Proof of the ASC's current CMS approval to participate in Medicare must accompany a provider application and a Medicaid contract (see part C of this section).
2. To continue its Medicaid enrollment, an ASC must maintain its CMS approval to participate in Medicare.
   a. The State Survey Agency periodically performs recertifications and forwards its certification and recommendation to its CMS Regional Office.
   b. To remain enrolled in Arkansas Medicaid, an ASC must ensure that Arkansas Medicaid's Provider Enrollment Unit has on file at all times (submitted within 30 days of issuance) a copy of the ASC's most recent CMS approval to participate in Medicare.
   c. Retraction or denial of CMS approval to participate in Medicare automatically terminates a provider's Arkansas Medicaid enrollment.

C An ASC must complete and submit to the Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). View or print Provider Enrollment Unit contact information.**

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

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.

201.200 Arkansas Medicaid Participation Requirements for ASCs in Bordering-State Trade-Area Cities 11-1-07

A. An ASC in a bordering-state trade area city (limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas) must be licensed as an Ambulatory Surgical Center by the appropriate licensing agency within its home state.

1. A copy of the ASC's current state license must accompany the provider application and Medicaid contract.
2. Enrolled ASC providers must submit copies of subsequent licenses within 30 days of a license's issuance.
3. Failure to maintain proof of licensure will result in termination of an ASC provider's Arkansas Medicaid contract.

B. A trade area city ASC must have CMS approval (following certification and recommendation by its State Survey Agency) to participate as a Title XVIII (Medicare) provider.

1. Proof of the ASC's current CMS approval to participate in Medicare must accompany a provider application and a Medicaid contract (see part C of this section).
2. To continue its Medicaid enrollment, an ASC must maintain its CMS approval to participate in Medicare.
   a. State Survey Agencies periodically perform recertifications and forward their certifications and recommendations to their CMS Regional Office.
   b. To remain enrolled in Arkansas Medicaid, an ASC must ensure that Arkansas Medicaid's Provider Enrollment Unit has on file at all times (submitted within 30 days of issuance) a copy of the ASC's most recent CMS approval to participate in Medicare.
   c. Retraction or denial of CMS approval to participate in Medicare automatically terminates a provider's Arkansas Medicaid enrollment.

C A trade area city ASC must complete and submit to the Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). View or print Provider Enrollment Unit contact information.**

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

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 Bordering-State ASCs Not Located in Trade Area Cities 11-1-07

Bordering-state ASCs that are not in any of the specified trade area cities may not enroll in Arkansas Medicaid.

201.400 ASCs in States not Bordering Arkansas 11-1-07

ASCs in states that do not border Arkansas may not enroll in Arkansas Medicaid.

202.000 Record Maintenance and Availability 11-1-07

A. ASC medical records must be kept for a period of 5 years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.

B. Providers are required to keep documentation and records as described in this manual and in official correspondence not yet incorporated into this manual.

C. Providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with delivery of medical assistance to any Medicaid beneficiary.

D. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, or a physician's order is required by law, by Medicaid rule, or both, must obtain a copy of the aforementioned prescription or order within five business days of the date it is written (or of the date given orally, when an oral order is permitted).

E. Providers must maintain a copy of each prescription, care plan, service plan or order in the beneficiary's medical record and follow all prescriptions, care plans, service plans and orders as required by law, by Medicaid rule, or both.

F. Providers must make available, on request, to any of the individuals and entities identified in subparts F1 through F3 below, all records related to any Medicaid beneficiary to whom the provider has furnished Medicaid-covered services for which the provider has sought and/or obtained reimbursement from Arkansas Medicaid, or for which the provider intends to bill Medicaid.

1. The Arkansas Division of Medical Services, which includes the Division's Medicaid Program Integrity Unit and authorized employees, contractors and designees of the Division
2. The Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General
3. Representatives of the Secretary of Health and Human Services

G. When requested records are stored off-premises or are in active use, the provider must certify in writing that the records in question are in active use or in off-premises storage; and the provider must set a date and hour when the records shall be made available to the requesting authority.

1. The date and hour when the records shall be made available to the requesting authority must be within three 3 working days of the time that access to the records is requested.
2. Providers are not allowed to delay access to requested records for reasons related to the provider's convenience.
3. Providers are not allowed to delay access to requested records by claiming the unavailability of sufficient personnel to fulfill the request.

H. Furnishing records on request to authorized individuals and agencies is a contractual obligation of providers enrolled in the Medicaid Program.

I. Sanctions will be imposed for failure to furnish records in accordance with official Medicaid guidelines. Section I of this manual contains detailed information regarding provider and beneficiary sanctions.

J. If any authorized audit determines that recoupment of Medicaid payments is necessary, the Division of Medical Services will accept additional documentation for only thirty days after the date of the notification of recoupment. Additional documentation will not be accepted later.

210.000 PROGRAM COVERAGE

210.100 Introduction 11-1-07

The Medical Assistance (Medicaid) Program helps eligible beneficiaries obtain medical care within the guidelines specified in Section I of this manual. Coverage of Medicaid benefits is based on medical necessity. Refer to the Glossary (Section IV) for the Program's definition of medical necessity.

210.200 Definition, Scope and Coverage of Ambulatory Surgical Center (ASC) Services 11-1-07

A. An ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients not requiring hospitalization.

1. Certain surgical or medical procedures may require prior authorization.
2. Certain surgeries may require paper billing with attached documentation.

B. Arkansas Medicaid covers as bundled or global services, CMS-approved outpatient surgeries and ASC facility services (such as the following), that are directly related to the surgeries.

1. Nursing, technician and related services
2. Use of the facilities where the surgical procedures are performed
3. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the performance of surgical procedures
4. Diagnostic or therapeutic services or items directly related to the performing of a surgical procedure
5. Specimen handling when applicable
6. Administrative, recordkeeping, and housekeeping items and services
7. Materials for anesthesia
8. Supervision of the services of an anesthetist by the operating surgeon
9. CRNA (employee of the ASC)

210.210 Exclusions, Exceptions and Special Conditions

210.211 Facility Service Exclusions 11-1-07

Global ASC facility services do not include other items and services that are covered under other Medicaid programs, including laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), collection of specimen by venipuncture when the specimen is sent elsewhere for testing, prosthetic devices, ambulance services; leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home.

210.212 Intraocular Lenses 11-1-07

Furnishing Intraocular lenses (IOLs) is an ASC facility service that Medicaid covers separately in the Ambulatory Surgical Center Program. See section 242.160 for billing instructions.

210.213 Physician Services 11-1-07

The surgical procedures, including all preoperative and post-operative services that are performed by a physician, osteopath, dentist or oral surgeon, are covered under the Arkansas Medicaid Physician Program or the Arkansas Medicaid Dental Program.

210.214 Laboratory, Radiology and Other Diagnostic Procedures 11-1-07

A. Laboratory, radiology and other diagnostic procedures not directly related to the surgical procedure are covered separately from the bundled ASC facility services.

B. These diagnostic procedures' separate coverage extends only to the Medicaid-enrolled entity or entities directly performing the diagnostic procedures.

216.600 Other Covered ASC Services

216.601 Cochlear Implants and External Sound Processors 11-01-07

A. The Arkansas Medicaid Program covers cochlear implantation for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. Also covered are the headset, microphone, transmitting coil and transmitter cable.

C. The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require prior authorization (PA) from AFMC.

1. The physician performing the procedure must obtain PA and ensure that the ASC has a copy of the authorization letter.

2. Refer to section 220.000 of this manual for PA procedures.

D. The operating physician must provide the implant device and necessary accessories; (Medicaid reimburses physicians, but not ASCs, for the implant devices and accessories).

216.602 Extracorporeal Shock Wave Lithotripsy (ESWL) 11-1-07

A. Medicaid coverage of ESWL in an ASC is global coverage that includes all related ASC facility services, including the use of the machine.

B. Medicaid covers subsequent ESWL treatment of the same kidney only after 60 or more days have passed since the kidney's previous treatment.

216.603 Organ or Disease Oriented Panels 11-1-07

A. Laboratory tests are not covered separately or individually when their date of service is the same as that of an organ or disease oriented panel of which they are a component

B. Performing an organ or disease oriented panel does not preclude coverage of other lab tests that are not components of that panel and are performed on the same date of service as that of the panel.

C. See the Pathology and Laboratory section of *CPT* for detailed information regarding organ and disease oriented panels.

216.700 Dental Surgery 11-1-07

A. Medicaid covers dental surgery in ASCs.

B. See section 242.110 for billing instructions.

216.800 Hyperbaric Oxygen Therapy 11-1-07

With respect to an ASC, this section is primarily for informational purposes; however, please note that the rules related to filing claims for hyperbaric oxygen therapy apply to ASCs as well as to physicians.

A. Hyperbaric oxygen therapy (HBO_2) involves exposing the body to oxygen under pressure greater than one atmosphere in specially constructed chambers holding one or more patients.

B. With some diagnoses, hyperbarics is only an adjunct to standard surgical therapy.

C. Patients must be assessed for contraindications such as sinus disease or claustrophobia before therapy.

216.810 HBO_2 Prior Approval 11-1-07

A. Except in emergency cases (such as for air embolism or carbon monoxide poisoning) prior approval of hyperbaric oxygen therapy is required, requests for which must include the following documentation.

1. A complete physician Subjective Objective Assessment and Plan (SOAP) note
2. A physical exam
3. Details of previous therapy and treatment failures, including antibiotic therapies and surgical interventions
4. Documentation of no measurable signs of healing for at least 30 consecutive days of wound care therapy before beginning HBO_2 therapy (for those diagnoses requiring this treatment plan)

B. Prior approval is issued by letter for a specific number of treatments.

C. Additional treatments beyond the approved number require another prior approval.

D. Requests for prior approval may be mailed or faxed: however, they must comply with HIPAA regulations regarding PHI.

E. The Medical Director may be contacted by telephone at 501-682-9868.

HBO_2 Treatment Prior Approval Contact Information

MAILING ADDRESS	**FAX TO:**
ATTN: Medical Director Division of Medical Services P.O. Box 1437, Slot S412 Little Rock, AR 72203-1437	501-682-8013 or 501-683-4124 ATTN: Medical Director

F. Refer to section 242.140 of this manual for HBO_2 billing instructions.

216.820 Usual Number of HBO_2 Treatments Per Diagnosis 11-1-07

ICD-9-CM Diagnosis Codes	Diagnosis Description	Number of Treatments
6396, 67300, 9580, 9991	Air or gas embolism	10
9930	Decompression sickness	10
986	Carbon monoxide poisoning	5
0400, 0383	Clostridial myositis and myonecrosis (gas gangrene)	10
8690-8691, 8871, 8873, 8875, 8877, 8971, 8973, 8975, 8977, 9251-9299, 99690-99699	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	See section 216.830
25070-25073, 44023, 44024, 44381-4439, 4540, 4542, 70700-7079, 9895, 99859	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
3240	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20
72886, 7854	Necrotizing soft tissue infections, immune compromise	30
73000-73020	Refractory osteomyelitis after aggressive surgical debridement	40
52689, 73010-73019, 7854, 9092, 990	Delayed radiation injury	60
99652, 99660-99670, V423	Compromised skin grafts and flaps	20
9400-9495	Thermal burns covering more than 20% of total body surface area (TBSA) and are deep, partial or full thickness injuries with involvement of hands, face, feet or perineum	40

216.830 HBO_2 Treatment Schedules 11-1-07

ICD-9-CM Diagnosis Codes	Injury Type	Number & Schedule of HBO_2 Treatments	Number of HBO_2 Treatments Before Peer Review	Comments
9251-929.9	Crush Injuries according to Gustilo	TID [a] 2 days BID [b] 2 days	6	

ICD-9-CM Diagnosis Codes	Injury Type	Number & Schedule of HBO_2 Treatments	Number of HBO_2 Treatments Before Peer Review	Comments
	classification	Daily for 2 days		
9585	Compartment syndrome, impending stage fasciotomy not required	TID [a] for 1 day	1	If post-fasciotomy, see problem wound recommendations
9400-9495, 99652, 99666-99670, V423	Threatened flaps and grafts	Same as for crush injuries	6	
92951-929.9	Problem wounds after primary management	BID [b] for 7days; daily 7 days	14	Post-fasciotomy wounds, complications and residual wounds after primary management of crush injuries
73000-73020	Refractory osteomyelitis	Daily for 21 days	21+	May require continuation of HBO_2 through 60 treatments, but reassessment and second stage peer review is recommended after 40 treatments

[a] Three times a day

[b] Twice a day

221.000 Prior Authorization Information 11-1-07

A. Refer to section 222.000 for CPT/HCPCS procedure codes of outpatient surgeries for which Arkansas Medicaid requires prior authorization (PA).

1. Clinical criteria for PA are whether the procedure is medically necessary and/or appropriate to the particular condition or disorder.
2. Written requests and documentation are not required initially, but providers requesting reconsideration of denied requests may be required to submit written documentation of informed consent, records of diagnostic procedures and results, verification of failed or minimally successful therapies and treatments or other written information.

B. Arkansas Foundation for Medical Care, Inc. (AFMC), Arkansas Medicaid's Quality Improvement Organization (QIO), reviews—and approves or denies—providers' requests for outpatient surgery PA.

1. Request PA for outpatient surgeries by telephone. **View or print AFMC contact information.** AFMC records all calls.
2. The performing physician must initiate the PA request; however, the call to AFMC may be made by a member of the physician's medical staff who is familiar with medical records and conversant in medical terminology; for instance, an RN or a physician's assistant.
3. The performing physician and the ASC must have on file in their patient's medical records the documentation of medical necessity that supports the telephoned request for PA.

C. Prior authorization does not guarantee payment: providers must comply with all Medicaid regulations related to the medical service.

1. The beneficiary must be eligible on the date of service.
2. The provider's Arkansas Medicaid enrollment must be effective for the date of service.
3. Most non-emergency outpatient surgeries require a referral from the beneficiary's primary care physician (PCP).
4. The PA number must be linked in Medicaid's claims processing system to the procedure billed (i.e. the procedure code billed must be the procedure code on the PA file).
5. The PA number must be linked to each provider that files a claim for the service; therefore, it occasionally may be necessary to contact AFMC to change or add provider identification numbers covered by a PA (for instance, the performing provider might change or a consulting or assisting physician may become involved).
6. Claims for some procedures must be submitted on paper and accompanied by operative reports, consent forms or other documentation and are not accepted electronically or without the required attachments.

230.100 ASC Reimbursement 11-1-07

Covered outpatient surgical procedures (including outpatient dental surgeries; see section 242.110 for billing instructions) are assigned to one of four groups for reimbursement purposes.

A. Medicaid has established a maximum allowable fee for each surgical group.

1. Reimbursement is the lesser of the billed charge or the maximum allowable fee for the applicable surgical group.
2. The maximum allowable fees are global fees that include all of the covered ASC facility services listed in section 210.200.
3. Lab, X-ray and machine tests that are not directly related to the surgery are covered separately.

B. Billings for surgical procedures that have not been assigned to a surgical group are manually reviewed and manually priced by medical professionals on staff at the Division of Medical Services (Medicaid), requiring that the claim be submitted on paper (UB-04 claim form) and accompanied by an operative report.

C. Some covered services payable to ASCs are not surgical or are not included in surgical groups for reimbursement purposes. Refer to sections 216.600 through 216.900 for coverage information regarding such services.

242.000 CMS-1450 Billing Procedures for ASCs

242.100 Special Billing

242.110 ASC Dental Billing 11-1-07

Outpatient dental surgical procedures performed in an ASC are billed to Medicaid with revenue codes rather than with HCPCS or CPT procedure codes. Bill Medicaid with the revenue code that is in the same outpatient surgical group as the surgery performed.

Revenue Code	Description
0361	Group I, Outpatient Dental Surgery
0360	Group II, Outpatient Dental Surgery
0369	Group III, Outpatient Dental Surgery
0509	Group IV, Outpatient Dental Surgery

242.120 Burn Dressings 11-1-07

A. Claims submitted for burn dressing changes must specify the date of occurrence of the injury.

B. Enter the applicable occurrence code and the date of the injury in the Occurrence Code and Occurrence Date fields.

242.140 Hyperbaric Oxygen Therapy Billing Procedures 11-1-07

Refer to sections 216.800 through 216.830 for coverage rules, diagnosis requirements and treatment schedules.

A. ASCs may bill Medicaid for only one unit of HBO_2 therapy per day regardless of the number of sessions in a given day.

B. The ASC's charge for each service date must include all hyperbaric oxygen therapy charges, regardless of the number of treatment sessions administered on that day.

C. ASCs may bill Medicaid for laboratory, X-ray, machine tests and outpatient surgery (in accordance with ASC Program rules regarding coverage of those services) in addition to billing Medicaid for the hyperbaric oxygen therapy.

D. ASCs must file UB-04 paper claims for hyperbaric oxygen therapy because the claims and attached documentation are reviewed for medical necessity.

1. A copy of the Medical Director's approval letter must accompany each claim.
2. Additional documentation accompanying each claim must include a clear description of the wound and the treatment's sequential number in the approved series (e.g., "3rd treatment of 5," or "Treatment #3.").

Procedure Code	Description
99183	ASC facility charge, hyperbaric oxygen pressurization (HBO_2), payable once per day regardless of the number of treatment sessions on a given day.

242.160 New Technology Intraocular Lens 11-1-07

A. The following new technology intraocular lens procedure codes must be billed on paper UB-04 claim forms.

B. Attach a copy of the invoice(s) because claims for these lenses are manually priced.

Procedure Code	Description
Q1003	New technology intraocular lens category 3
Q1004	New technology intraocular lens category 4
Q1005	New technology intraocular lens category 5