ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
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OFFICIAL NOTICE

DMS-2007-A-4	DMS-2007-II-6	DMS-2007-KK-5
DMS-2007-O-5	DMS-2007-L-6	DMS-2007-R-4
DMS-2007-X-2	DMS-2007-SS-2	DMS-2007-OO-5

TO: **Health Care Provider – Ambulatory Surgical Center; Certified Nurse-Midwife; Family Planning; Federally Qualified Health Center (FQHC); Hospital; Independent Lab; Nurse Practitioner; Physician; Rural Health Clinic (RHC) and Arkansas Department of Health**

DATE: **October 18, 2007**

SUBJECT: **FAMILY PLANNING SERVICES**

I. Background:

The Division of Medical Services issued an Official Notice (DMS-2006-A-4, DMS-2006-L-4, DMS-2006-0-3, DMS-2006-KK-4, DMS-2006-X-1, DMS-2006-R-4, DMS-2006-II-4, DMS-2006-00-3, DMS-2006-SS-3) dated June 20, 2006 regarding family planning services, including additional procedure codes covered for the effective dates of service on or after February 1, 2006. However, at the time, the system was unable to process the claims for the specific procedure codes and providers were instructed to hold claims until further notice.

The purpose of this Official Notice is to notify providers of the previously added Family Planning Services and that the claims for these services may now be filed. This notice also addresses the billing procedures for those claims that were held and are now past the filing deadline, or will be past the filing deadline in the next 90 days. Claims past the filing deadline *must* be received by **January 31, 2008**. Any claims filed that are over two (2) years old after **January 31, 2008**, will *not* be paid.

II. Special Instructions

Providers will have until January 31, 2008 to file claims that may be past the twelve (12) month filing deadline or claims for which the filing deadline will fall within this ninety (90) day window. Claims that are past the filing deadline must be submitted as a paper claim* to *the following address:

EDS/Research Analyst
P.O. Box 8036
Little Rock, AR 72203

NOTE: When submitting these claims that are past the filing deadline as described above, the provider must attach a memo indicating that the claims are impacted by *this* Family Planning Services Official Notice.

III. Lab Procedure Codes:

Effective for dates of service on or after February 1, 2006, Lab Procedure codes **87491** and **87591** are available as Family Planning procedure codes.

Professional claims for procedure codes **87491** and **87591** must include modifier **FP**. Whether a claim is paper or electronic, a family planning diagnosis code *must* be listed as primary on each detail.

Facilities billing for procedure codes **87491** and **87591** as family planning services *must* have a primary diagnosis of family planning on the claim, whether billed electronically or on paper.

IV. Procedures Relating to 58565 "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants" (Essure):

A. Effective for dates of service on and after **March 1, 2006**, professional claims for conscious sedation (procedure codes **99144** and **99145**) may be covered as a family planning service only when administered in conjunction with the Essure procedure **(58565)**.

NOTE: When 99144 and 99145 are billed for family planning, there must be a paid or pending professional claim for 58565 when billing for the same date of service.

1. To file claims for professional services, use modifier **FP**. Whether billing electronically or on paper, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

   Claims for professional services that were provided in an outpatient hospital clinic should not include modifiers. Whether billing electronically or on paper, the primary detail diagnosis for each procedure must be a family planning diagnosis code.

2. Facility fees for **99144** and **99145** are included in the facility fee for **58565**.

B. Effective for dates of service on or after **February 1, 2006**, procedure codes **58340, 58345, 72190, 74740,** and **74742** are payable as **family planning services** only when provided within 6 months of the Essure **(58565)** date of service.

NOTE: Payment of any of these procedure codes requires that 58565 (the Essure procedure) is already a *paid* or *pending* claim.

1. Professional claims for procedure codes **58340** and **58345** must be filed with modifier **FP.**

   The following instructions apply when procedures **58340** and **58345** are performed in an outpatient clinic associated with a hospital:

   Claims for professional services for **58340** or **58345,** when provided in an outpatient clinic associated with a hospital, are to be filed with no modifiers. Whether billing electronically or on paper, a family planning diagnosis code *must* be listed as primary on the claim detail.

   Facility claims for **58340** or **58345** also require a primary diagnosis of family planning whether billing electronically or on paper.

   Professional claims for procedures **72190**, **74740**, and **74742** must be filed with modifier **FP**. Whether billing electronically or on paper, a family planning diagnosis code *must* be listed as primary on the claim detail.

2. When these radiology procedures are performed as family planning services in an outpatient hospital or an outpatient hospital clinic, bill Medicaid in accordance with the following instructions:

Claims for the professional component of procedure codes **72190, 74740**, and **74742** are to be billed with no modifiers. Whether billing electronically or on paper, a family planning diagnosis code must be listed as primary on each detail.

3. Facility claims (outpatient hospital or outpatient hospital clinic) for procedure code **72190** requires a family planning diagnosis code as the primary diagnosis.

C. Procedure codes **J1055, 11976**, and **58301** are currently payable family planning services. Effective for dates of service on and after **February 1, 2006**, these procedures are covered up to six months, as necessary for follow-up services to **58565** (Essure). When provided for post-Essure **(58565)** follow-up care, billing protocol for **J1055**, **11976**, and **58301** is unchanged for all providers.

All visits related to post-Essure services during the 6 months following the Essure procedure are included in the allowable fee for **58565**.

All facility fees for the services for **J1055**, **11976**, and **58301** are bundled under **58565** if provided on the same Date of Service as **58565**.

Additionally, all other established billing requirements must be met in order for a claim to be approved for payment.

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 (TDD Only).

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at the 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*.**

Roy Jeffus, Director