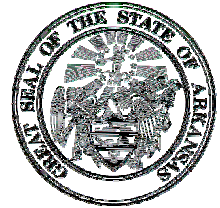




Division of Medical Services Program Planning & Development

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480 · TDD: 501-682-6789



OFFICIAL NOTICE

DMS-2008-A-2	DMS-2008-G-1	DMS-2008-L-2	DMS-2008-R-2
DMS-2008-YC-1	DMS-2008-AR-1	DMS-2008-CA-2	DMS-2008-SS-1
DMS-2008-EE-2	DMS-2008-00-2	DMS-2008-0-2	DMS-2008-Z-2
DMS-2008-DD-1	DMS-2008-QQ-1	DMS-2008-SB-1	DMS-2008-HH-2
DMS-2008-II-2	DMS-2008-KK-2	DMS-2008-YY-1	DMS-2008-U-1
DMS-2008-C-1			

TO: Health Care Providers – Ambulatory Surgical Center; ARKids First-B; Certified Nurse-Midwife; Certified Registered Nurse Anesthetist (CRNA); Child Health Management Services (CHMS); Child Health Services (EPSDT); Critical Access Hospital; End Stage Renal Disease; Federally Qualified Health Center (FQHC); Hospital; Independent Lab; 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 Care and Arkansas Department of Health

DATE: March 1, 2008

SUBJECT: 2008 CPT Procedure Code Conversion

I. General Information

A review of the 2008 CPT procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT 2008 procedure codes for dates of service on and after March 1, 2008. Please add this information to your Medicaid provider manual until revised manual sections have been included in future updates.

Procedure codes that are identified as deletions in CPT 2008 (Appendix B) are **non-payable** for dates of service on and after March 1, 2008.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2008 CPT and HCPCS conversions.

II. Non-Covered CPT 2008 Procedure Codes

- A. Effective for dates of service on and after March 1, 2008, the following CPT procedure codes are non-payable. Arkansas Medicaid does not cover the services they represent.

21073	34806	90661	90662	90663	93982	96125
98966	98967	98968	98969	99174	99366	99367
99368	99408	99409	99441	99442	99443	99444
99605	99606	99607				

- B. All CPT 2008 procedure codes listed in **Category II** and **Category III** are **non-covered**.

- C. Effective for dates of service on and after March 1, 2008, the following new 2008 CPT procedure codes are not payable to Outpatient Hospitals and Ambulatory Surgical Centers because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

20985	20986	20987	22208	33257	33258
33259	36591	36592	90770	90771	90776

- D. Effective for dates of service on and after March 1, 2008, the following new 2008 CPT procedure codes are not payable to physicians and certified nurse midwives because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

99406	99407
--------------	--------------

- E. Effective for dates of service on and after March 1, 2008, the following currently payable 2008 CPT procedure codes have revised descriptions and are no longer payable to outpatient hospitals and ambulatory surgical centers because these services are covered by another CPT procedure code, another HCPCS code, or another revenue code.

20930	20931	20936	20937	20938	22840
22841	22842	22843	22844	22845	22846
22847	22848	22851	33517	33518	33519
33521	33522	33523	35600	49568	51797

- F. Revised CPT Descriptions Affecting Multiple Provider Types

Effective for dates of service on and after March 1, 2008, procedure code **90698** will become non-payable for all provider types.

Official Notice

DMS-2008-A-2
DMS-2008-YC-1
DMS-2008-EE-2
DMS-2008-DD-1
DMS-2008-II-2
DMS-2008-C-1

DMS-2008-G-1
DMS-2008-AR-1
DMS-2008-00-2
DMS-2008-QQ-1
DMS-2008-KK-2

DMS-2008-L-2
DMS-2008-CA-2
DMS-2008-0-2
DMS-2008-SB-1
DMS-2008-YY-1

DMS-2008-R-2
DMS-2008-SS-1
DMS-2008-Z-2
DMS-2008-HH-2
DMS-2008-U-1

Page 3

III. Prior Authorization

- A. The following 2008 CPT procedure codes require prior authorization from AFMC.

27416 28446 58570 58571 58572 58573

- B. The following existing CPT procedure codes will become payable effective for dates of service on or after March 1, 2008. The procedure codes require prior authorization from AFMC.

58541 58542 58543 58544

IV. CPT 2008 Procedure Codes Manually Reviewed

Effective for dates of service on and after March 1, 2008, the new CPT procedure codes listed below are manually reviewed before payment. Providers must submit claims as indicated below:

- A. CPT Procedure Code **90284** will be approved for payment based on a diagnosis code that proves medical necessity.
- B. Effective for dates of service on and after March 1, 2008, the following CPT procedure codes require a paper claim with form DMS-2606 attached.

58570 58571 58572 58573

V. Current Procedure Codes to Become Payable

The following existing CPT procedure codes will become payable effective for dates of service on or after March 1, 2008 for physicians, hospitals and ambulatory surgical centers. These procedure codes will be manually reviewed prior to payment and require prior authorization from AFMC and a paper claim with form DMS-2606 attached.

58541 58542 58543 58544

VI. New Local HCPCS Procedure Code

Effective for dates of service on and after March 1, 2008, the following locally assigned HCPCS procedure code is payable to Arkansas Medicaid physician providers. This procedure code requires manual review prior to payment and must be billed on a paper claim form with form DMS-2606 attached. See sections 272.100, 292.440, 292.444 and 292.447 of the Physician Provider Manual.

Procedure Code

Description

Z9950

Anesthesia for laparoscopic supracervical hysterectomy

VII. The following codes are payable to podiatrists:

29904 29905 29906 29907 36591 36592

Official Notice

DMS-2008-A-2
DMS-2008-YC-1
DMS-2008-EE-2
DMS-2008-DD-1
DMS-2008-II-2
DMS-2008-C-1

DMS-2008-G-1
DMS-2008-AR-1
DMS-2008-00-2
DMS-2008-QQ-1
DMS-2008-KK-2

DMS-2008-L-2
DMS-2008-CA-2
DMS-2008-0-2
DMS-2008-SB-1
DMS-2008-YY-1

DMS-2008-R-2
DMS-2008-SS-1
DMS-2008-Z-2
DMS-2008-HH-2
DMS-2008-U-1

Page 4

VIII. The following codes are payable to oral surgeons:

36591 36592

IX. Effective for dates of service on or after March 1, 2008 the following CPT procedure codes are payable to Certified Nurse Midwives:

36591 36592 90769 90770 90771

X. CPT Procedure Codes Payable to Ambulatory Surgical Centers

A. The following CPT 2008 procedure codes are payable to ambulatory surgical centers.

CPT 2008 Procedure Codes Payable to Ambulatory Surgical Centers

20555	22206	22207	24357	24358	24359
27267	27268	27269	27416	27726	27767
27768	27769	28446	29828	29904	29905
29906	29907	32421	32422	32550	32551
32560	33864	35523	36593	41019	49203
49204	49205	49440	49441	49442	49446
49450	49451	49452	49460	49465	50385
50386	50593	51100	51101	51102	52649
55920	57285	57423	58570	58571	58572
58573	60300	67041	67042	67043	67113
67229	68816	75557	75558	75559	75560
75561	75562	75563	75564	80047	82610
83993	84704	86356	86486	87500	87809
88381	89322	89331	95980	95981	95982

B. The following current CPT procedure codes are payable to Ambulatory Surgical Centers:

58541 58542 58543 58544

Official Notice

DMS-2008-A-2
DMS-2008-YC-1
DMS-2008-EE-2
DMS-2008-DD-1
DMS-2008-II-2
DMS-2008-C-1

DMS-2008-G-1
DMS-2008-AR-1
DMS-2008-00-2
DMS-2008-QQ-1
DMS-2008-KK-2

DMS-2008-L-2
DMS-2008-CA-2
DMS-2008-0-2
DMS-2008-SB-1
DMS-2008-YY-1

DMS-2008-R-2
DMS-2008-SS-1
DMS-2008-Z-2
DMS-2008-HH-2
DMS-2008-U-1

Page 5

XI. Additional Information

Procedure code **84704** is exempt from ARKids First-B copayment.

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) 682-8323 or (501) 682-6789 (TDD); In-State Toll Free at 800-482-1141 or Out-of-State Toll Free at 800-482-5850. The Toll-Free lines are voice only.

Please direct inquiries regarding this Official Notice to the EDS Provider Assistance Center at 501-376-2211 or (In-State Toll Free) 800-457-4454.

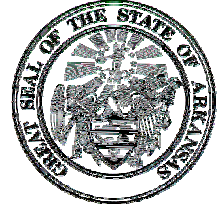
Arkansas Medicaid provider manuals, update transmittals, proposed rules for public comment, official notices and remittance advice (RA) messages can be downloaded without charge from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Roy Jeffus, Director



Division of Medical Services Program Planning & Development

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OFFICIAL NOTICE

DMS-2008-A-4	DMS-2008-AR-3	DMS-2008-E-1	DMS-2008-I-4
DMS-2008-J-3	DMS-2008-KK-4	DMS-2008-L-4	DMS-2008-R-4
DMS-2008-S-4	DMS-2008-SS-2	DMS-2008-U-3	DMS-2008-X-3
DMS-2008-Y-3	DMS-2008-II-3		

TO: Health Care Providers – AHECS, Arkansas Department of Health, ARKids First-B, Ambulatory Surgical Center, Certified Nurse Midwife, Dental, Family Planning, Federally Qualified Health Center (FQHC), Home Health, Hospital, Independent Lab, Independent Radiology, Nurse Practitioner, Physician, Private Duty Nursing, Prosthetics, Rehabilitation Center

DATE: March 1, 2008

SUBJECT: 2008 HCPCS Procedure Code Conversion

I. General Information

A review of the 2008 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, 2008.

II. 2008 HCPCS Payable Procedure Codes Tables Information

Procedure codes have been broken into separate tables. Tables have been created for each affected provider type (e.g.: prosthetics, home health etc.).

The tables of payable procedure codes for all affected programs 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 of the list contains the HCPCS procedure codes. The procedure code may be shown on multiple lines on the table, depending on the applicable modifier based on the service performed.

II. **2008 HCPCS Payable Procedure Code Tables Information (continued)**

The second 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. Providers should consult their program manual to review the process involved in manual pricing.

Certain procedure codes are covered only when the primary diagnosis is covered within a specific diagnosis range. This information is used, for example, by physicians, hospitals and others. The third and fourth columns, for all affected programs, indicate the beginning and ending range of diagnoses for which a procedure code may be used. (e.g.: 0530 through 0549).

The fifth column contains information about the diagnosis list for which a procedure code may be used. (See Section III below for more information about diagnosis range and lists.)

The sixth column indicates whether a procedure is subject to 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 seventh 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” indicates that 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 eighth column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.

The ninth column indicates a procedure code requiring a prior approval letter from the Arkansas Medicaid Medical Director. The letter “Y” in the column indicates that a procedure code requires a prior approval letter and an “N” indicates that a prior approval letter is not required. A prior approval letter, when required, must be attached to the paper claim when it is filed.

Please Note: The Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2008 CPT and HCPCS conversions.

III. **Diagnosis Range and Diagnosis Lists**

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

Diagnosis List 003

042, 140.0 through 208.91

230.0 through 238.9

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

The following information is related to procedure codes found in the ASC table.

J7321, J7322, J7323 J7324^K

Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). A written request must be submitted to the Division of Medical Services Utilization Review Section.

The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider number and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

The contact information for Utilization Review is:

In-State WATS:

Direct: (501) 682-8340

Toll Free: 1-800-482-5850, Extension 28340

FAX: (501) 682-8013

Mailing Arkansas Division of Medical Services Utilization Review Section

Address: P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

S3800^H

This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD-9-CM diagnosis code of 335.20 and symptoms of muscle weakness. (2) documentation of muscle testing must be provided. (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.

Official Notice**DMS-2008-A-4****DMS-2008-AR-3****DMS-2008-E-1****DMS-2008-I-4****DMS-2008-J-3****DMS-2008-KK-4****DMS-2008-L-4****DMS-2008-R-4****DMS-2008-S-4****DMS-2008-SS-2****DMS-2008-U-3****DMS-2008-X-3****DMS-2008-Y-3****DMS-2008-II-3**

Page 4

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

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
J7321 ^K	N				N	Y		N
J7322 ^K	N				N	Y		N
J7323 ^K	N				N	Y		N
J7324 ^K	N				N	Y		N
S2066	Y				N	Y		N
S2067	Y				N	Y		N
S3800 ^H	Y	33520	33520		N	Y	▲	N

▲ Bill any applicable modifiers with the procedure code.

V. **HCPCS Procedure Codes Payable to ARKids First-B**

B4087 This procedure code is included in the \$125 per month ARKids First-B medical supply benefit limit.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
B4087	N				N	N	NU	N

VI. **HCPCS Procedure Codes Payable to Certified Nurse Midwife**

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

The following information is related to procedure codes found in the family planning clinic table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol listed below applies to that procedure code in the grid.

J7307^F This procedure code requires a primary family planning detail diagnosis code. It is covered as a family planning benefit for “regular Medicaid” beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit-limited to two per seven years per beneficiary.

* Procedure codes **J2791** and **J7307** are exempt from ARKids First-B co-pay.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
*J2791	N				N	N		N
*J7307 ^F	N				N	N	FP	N

VII. HCPSC Procedure Codes Payable to Family Planning Clinic

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

The following information is related to procedure codes found in the family planning clinic table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol listed below applies to that procedure code in the grid.

J7307^F This procedure code requires a primary family planning detail diagnosis code. It is covered as a family planning benefit for “regular Medicaid” beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit-limited to two per seven years per beneficiary.

* Procedure code **J7307** is exempt from ARKids First-B co-pay.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
*J7307 ^F	N				N	N	FP	N

VIII. HCPSC Procedure Codes Payable to Federally Qualified Health Centers (FQHC)

Family planning services require a primary family planning diagnosis code.

The following information is related to procedure codes found in the FQHC table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol listed below applies to that procedure code in the grid.

7307^F This procedure code is covered as a family planning benefit for “regular Medicaid” beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit limited to two per seven years per beneficiary.

* Procedure code **J7307** is exempt from ARKids First-B co-pay.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
*J7307 ^F	N				N	N	FP	N

Official Notice

DMS-2008-A-4

DMS-2008-J-3

DMS-2008-S-4

DMS-2008-Y-3

DMS-2008-AR-3

DMS-2008-KK-4

DMS-2008-SS-2

DMS-2008-II-3

DMS-2008-E-1

DMS-2008-L-4

DMS-2008-U-3

DMS-2008-I-4

DMS-2008-R-4

DMS-2008-X-3

Page 6

IX. HCPCS Procedure Codes Payable to Arkansas Department of Health

* Procedure code **J2791** is exempt from ARKids First-B co-pay.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
*J2791	N				N	N		N

X. HCPCS Procedure Codes Payable to Home Health

B4087 This procedure code is included in the \$250.00 per month medical supply benefit limit.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
B4087	N				N	N		N

XI. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes found in the hospital table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol listed below applies to that procedure code in the grid.

C9240^A Coverage of this procedure code requires an ICD-9-CM diagnosis code of 174.0-175.9. Any one of the diagnosis codes from the above listed ranges is acceptable. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

J0220^B This procedure code requires an ICD-9-CM diagnosis code of 271.0. An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

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

- J1743^C** This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSII). An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J2323^D** A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. A history and physical showing a relapse of multiple sclerosis must be submitted. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J2778^E** This procedure code requires an ICD-9-CM diagnosis code of 362.50 or 362.52 as the principle diagnosis. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J7307^F** Family planning services require a family planning diagnosis code. This procedure code is covered as a family planning benefit for “regular Medicaid” beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit-limited to two per seven years per beneficiary.
- J9303^G** This procedure code requires an ICD-9-CM diagnosis code of 153.0-154.8. A prior approval letter from the DMS Medical Director is required for billing and must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- S3800^H** This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD-9-CM diagnosis code of 335.20 and symptoms of muscle weakness. (2) documentation of muscle testing must be provided. (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.

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

J7321, J7322, J7323 J7324^K

Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). A written request must be submitted to the Division of Medical Services Utilization Review Section.

The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider number and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

The contact information for Utilization Review is:

In-State WATS:

Direct: (501) 682-8340

Toll Free: 1-800-482-5850 Extension 28340

FAX: (501) 682-8013

Mailing Arkansas Division of Medical Services Utilization Review Section

Address: P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

* Procedure codes **J2791** and **J7307** are exempt from ARKids First-B co-pay.

- Procedure codes **J1561**, **J1568** and **J1569** will be reviewed for medical necessity based on diagnosis code.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
A9572	N				N	N		N
A9576	N				N	N		N
A9577	N				N	N		N
A9578	N				N	N		N
A9579	N				N	N		N
C2698	Y				N	N		N
C2699	Y				N	N		N
C9237	Y				N	N		N
C9238	Y				N	N		N
C9239	Y			003	N	N		N
C9240 ^A	Y	1740	1759		Y	N		Y
J0220 ^B	N	2710	2710		Y	N		Y
J0400	N				N	N		N
J1561•	N				Y	N		N
J1568•	N				Y	N		N

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

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
J1569 [●]	N				Y	N		N
J1571	N				N	N		N
J1572	N				N	N		N
J1573	N				N	N		N
J1743 ^C	N	2775	2775		Y	N		Y
J2323 ^D	N				Y	N		Y
J2724	N				N	N		N
J2778 ^E	N				Y	N		Y
*J2791	N				N	N		N
J3488	N				N	N		N
*J7307 ^F	N				N	N		N
J7321 ^K	N				N	Y		N
J7322 ^K	N				N	Y		N
J7323 ^K	N				N	Y		N
J7324 ^K	N				N	Y		N
J7347	N				N	N		N
J7349	N				N	N		N
J9226	N			003	N	N		N
J9303 ^G	N	1530	1548		Y	N		Y
S2066	Y				N	Y	▲	N
S2067	Y				N	Y	▲	N
S3800 ^H	Y	33520	33520		N	Y	▲	N

▲ Bill any applicable modifiers with the procedure code.

XII. **HCPCS Procedures Codes Payable to Independent Lab**

S3800^H This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD-9-CM diagnosis code of 335.20 and symptoms of muscle weakness. (2) documentation of muscle testing must be provided. (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
S3800 ^H	Y	33520	33520		N	Y	▲	N

▲ Bill any applicable modifiers with the procedure code.

Official Notice**DMS-2008-A-4****DMS-2008-AR-3****DMS-2008-E-1****DMS-2008-I-4****DMS-2008-J-3****DMS-2008-KK-4****DMS-2008-L-4****DMS-2008-R-4****DMS-2008-S-4****DMS-2008-SS-2****DMS-2008-U-3****DMS-2008-X-3****DMS-2008-Y-3****DMS-2008-II-3****Page10****XIII. HCPCS Procedures Codes Payable to Independent Radiology**

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
A9572	N				N	N		N
A9576	N				N	N		N
A9577	N				N	N		N
A9578	N				N	N		N
A9579	N				N	N		N
C2698	Y				N	N	▲	N
C2699	Y				N	N	▲	N

▲ Bill any applicable modifiers with the procedure code.

XIV. HCPCS Procedure Codes Payable to Nurse Practitioners

• Procedure codes **J1561** will be reviewed for medical necessity base on diagnosis code.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
J1561•	N				Y	N		N

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

The following information is related to procedure codes found in the physicians and AHECs section table. Reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the grid.

C9240^A Coverage of this procedure code requires an ICD-9-CM diagnosis code of 174.0-175.9. Any one of the diagnosis codes from the above listed ranges is acceptable. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

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

- J0220^B** This procedure code requires an ICD-9-CM diagnosis code of 271.0. An evaluation by a physician with a specialty in clinical genetics documenting progress is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J1743^C** This procedure code requires an ICD-9-CM diagnosis code of 277.5 (MPSII). An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J2323^D** A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each paper claim. A history and physical showing a relapse of multiple sclerosis must be submitted. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J2778^E** This procedure code requires an ICD-9-CM diagnosis code of 362.50 or 362.52 as the principle diagnosis. A prior approval letter from the DMS Medical Director is required for billing and a copy must be attached to each claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.
- J7307^F** Family planning services require a family planning diagnosis code. This procedure code is covered as a family planning benefit for “regular Medicaid” beneficiaries. It is not covered for aid category 69 beneficiaries. It is benefit-limited to two per seven years per beneficiary.

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

J9303^G This procedure code requires an ICD-9-CM diagnosis code of 153.0-154.8. A prior approval letter from the DMS Medical Director is required for billing and must be attached to each paper claim. Review the appropriate provider manual for additional coverage information and instructions for requesting prior approval or contact the DMS Medical Director at (501)-682-9868.

S3800^H This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD-9-CM diagnosis code of 335.20 and symptoms of muscle weakness. (2) documentation of muscle testing must be provided. (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.

J7321, J7322, J7323 J7324^K

Prior authorization must be obtained through the Utilization Review Section of the Division of Medical Services (DMS). Providers must specify the brand name of Hyaluronon or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section.

The request must include the patient's name, Medicaid ID number, physician's name, physician's Medicaid provider number and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

The contact information for Utilization Review is:

In-State WATS:

Direct: (501) 682-8340

Toll Free: 1-800-482-5850 Extension 28340

FAX: (501) 682-8013

Mailing Arkansas Division of Medical Services Utilization Review Section

Address: P. O. Box 1437, Slot S413
Little Rock, AR 72203-1437

* Procedure codes **J2791** and **J7307** are exempt from PCP referral and exempt from ARKids First-B co-pay.

• Procedure codes **J1561**, **J1568** and **J1569** will be reviewed for medical necessity base on diagnosis code.

Official Notice
DMS-2008-A-4
DMS-2008-AR-3
DMS-2008-E-1
DMS-2008-I-4
DMS-2008-J-3
DMS-2008-KK-4
DMS-2008-L-4
DMS-2008-R-4
DMS-2008-S-4
DMS-2008-SS-2
DMS-2008-U-3
DMS-2008-X-3
DMS-2008-Y-3
DMS-2008-II-3
Page 13
XV. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs) (Continued)

Effective for dates of service on and after March 1, 2008, locally assigned HCPCS procedure code **Z9950**, “Anesthesia for laparoscopic supracervical hysterectomy,” is payable to physicians and CRNAs. The procedure requires manual review before payment and it must be billed on a redlined paper claim form with form DMS-2606 attached.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
A9572	N				N	N		N
A9576	N				N	N		N
A9577	N				N	N		N
A9578	N				N	N		N
A9579	N				N	N		N
C9237	Y				N	N		N
C9238	Y				N	N		N
C9239	Y			003	N	N		N
C9240 ^A	Y	1740	1759		Y	N		Y
J0220 ^B	N	2710	2710		Y	N		Y
J0400	N				N	N		N
J1561●	N				Y	N		N
J1568●	N				Y	N		N
J1569●	N				Y	N		N
J1571	N				N	N		N
J1572	N				N	N		N
J1573	N				N	N		N
J1743 ^C	N	2775	2775		Y	N		Y
J2323 ^D	N				Y	N		Y
J2724	N				N	N		N
J2778 ^E	N				Y	N		Y
*J2791	N				N	N		N
J3488	N				N	N		N
*J7307 ^F	N				N	N	FP	N
J7321	N				N	Y		N
J7322	N				N	Y		N
J7323	N				N	Y		N
J7324	N				N	Y		N
J9226	N			003	N	N		N
J9303 ^G	N	1530	1548		Y	N		Y
S2066	Y				N	Y	▲	N
S2067	Y				N	Y	▲	N
S3800 ^H	Y	33520	33520		N	Y	▲	N
Z9950	N				Y	N		N

▲ Bill any applicable modifiers with the procedure code.

Official Notice**DMS-2008-A-4****DMS-2008-AR-3****DMS-2008-E-1****DMS-2008-I-4****DMS-2008-J-3****DMS-2008-KK-4****DMS-2008-L-4****DMS-2008-R-4****DMS-2008-S-4****DMS-2008-SS-2****DMS-2008-U-3****DMS-2008-X-3****DMS-2008-Y-3****DMS-2008-II-3**

Page 14

XVI. HCPCS Procedure Codes Payable to Private Duty Nursing

B4087 This procedure code is included in the medical supply benefit limit of \$80.00 per month.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
B4087	N				N	N		N

XVII. HCPCS Procedure Codes Payable to Prosthetics

B4087 This procedure code is included in the medical supply benefit limit of \$250.00 per month.

L3925 This procedure code is included in the orthotic benefit limit of \$3000.00 per SFY for beneficiaries age 21 and over.

L3929 This procedure code is included in the orthotic benefit limit of \$3000.00 per SFY for beneficiaries age 21 and over

L3931 This procedure code is included in the orthotic benefit limit of \$3000.00 per SFY for beneficiaries age 21 and over.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
B4087	N				N	N	NU	N
L3925	N				N	N	NU	N
L3925	N				N	N	EP	N
L3929	N				N	N	NU	N
L3929	N				N	N	EP	N
L3931	N				N	N	NU	N
L3931	N				N	N	EP	N

XVIII. HCPCS Procedure Codes Payable to Rehabilitation Center

S3800^H This procedure code requires prior authorization by AFMC based on the following criteria: (1) an ICD-9-CM diagnosis code of 335.20 and symptoms of muscle weakness. (2) documentation of muscle testing must be provided. (3) a completed evaluation by a neurologist to rule out other causes of muscle weakness.

2008 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
S3800 ^H	Y	33520	33520		N	Y	▲	N

▲ Bill any applicable modifiers with the procedure code.

XIX. Non-Covered 2008 HCPCS with Elements of CPT or Other Procedure Codes

- A. The following 2008 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.

A7027	A7029	C9352	C9354	E0328	E2227	E2312	E2397	G8453	Q9965	Q9967
A7028	A9274	C9353	C9355	E0329	E2228	E2313	G8402	J7348	Q9966	S9152

- B. Effective for dates of service on and after March 1, 2008, HCPCS procedure code **S2078** will not be payable because this service is now covered by a CPT procedure code.

XX. Non-Covered 2008 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A4252	B4088	C9728	G8373	G8388	G8407	G8426	G8441	G8458	G8473	J7603	S0272
A4648	C2638	D2970	G8374	G8389	G8408	G8427	G8442	G8459	G8474	J7604	S0273
A4650	C2639	E0856	G8375	G8390	G8409	G8428	G8443	G8460	G8475	J7605	S0274
A5083	C2640	G0396	G8376	G8391	G8410	G8429	G8445	G8461	G8476	J7632	S3905
A6413	C2641	G0397	G8377	G8395	G8415	G8430	G8446	G8462	G8477	J7676	T1503
A9155	C2642	G8351	G8378	G8396	G8416	G8431	G8447	G8463	G8478	L3925	V2787
A9276	C2643	G8354	G8379	G8397	G8417	G8432	G8448	G8464	G8479	L3927	
A9277	C8921	G8357	G8380	G8398	G8418	G8433	G8449	G8465	G8480	L7611	
A9278	C8922	G8360	G8381	G8399	G8419	G8434	G8450	G8466	G8481	L7612	
A9283	C8923	G8362	G8382	G8400	G8420	G8435	G8451	G8467	G8482	L7613	
A9501	C8924	G8365	G8383	G8401	G8421	G8436	G8452	G8468	G8483	L7614	
A9509	C8925	G8367	G8384	G8403	G8422	G8437	G8454	G8469	G8484	L7621	
A9569	C8926	G8370	G8385	G8404	G8423	G8438	G8455	G8470	G9140	L7622	
A9570	C8927	G8371	G8386	G8405	G8424	G8439	G8456	G8471	J1300	S0270	
A9571	C8928	G8372	G8387	G8406	G8425	G8440	G8457	G8472	J7602	S0271	

XXI. Miscellaneous Changes

- A. Several previously payable HCPCS codes have been deleted in the 2008 HCPCS conversion. Providers may use their current HCPCS book to find replacement codes.
- B. Effective for dates of service on and after March 1, 2008, the procedure codes listed below have been added for beneficiaries age 21 and over. The procedure codes are included in the monthly incontinence supply benefit limit.

T4530 Pediatric sized disposable incontinence product, brief/diaper, large size, each

Official Notice

DMS-2008-A-4

DMS-2008-J-3

DMS-2008-S-4

DMS-2008-Y-3

Page 16

DMS-2008-AR-3

DMS-2008-KK-4

DMS-2008-SS-2

DMS-2008-II-3

DMS-2008-E-1

DMS-2008-L-4

DMS-2008-U-3

DMS-2008-I-4

DMS-2008-R-4

DMS-2008-X-3

XXI. **Miscellaneous Changes (Continued)**

T4532 Pediatric size disposable incontinence product, protective underwear/pull-on, large size, each

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) 682-8323 or (501) 682-6789 (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.

Roy Jeffus, Director