ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

OFFICIAL NOTICE

DMS-2009-A-12	DMS-2009-AR-7	DMS-2009-O-9	DMS-2009-HH-8
DMS-2009-C-4	DMS-2009-G-7	DMS-2009-CA-9	DMS-2009-Z-9
DMS-2009-II-13	DMS-2009-L-13	DMS-2009-SS-6	DMS-2009-DD-2
DMS-2009-KK-12	DMS-2009-R-13	DMS-2009-EE-8	DMS-2009-QQ-5
DMS-2009-YY-3	DMS-2009-YC-3	DMS-2009-OO-11	DMS-2009-SB-3
DMS-2009-U-4			

TO: **Health Care Provider – 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, 2009**

SUBJECT: **2009 CPT Procedure Code Conversion**

I. General Information

A review of the 2009 CPT procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT 2009 procedure codes for dates of service on and after March 1, 2009.

Procedure codes that are identified as deletions in CPT 2009 (Appendix B) are **non-payable** for dates of service on and after March 1, 2009.

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 2009 CPT and HCPCS conversions.

II. **Non-Covered 2009 CPT Procedure Codes**

A. Effective for dates of service on and after March 1, 2009, the following CPT procedure codes are non-payable.

65757	90650	90738	90951	90952	90953	90954
90955	90956	90957	90958	90959	90960	90961
90962	90963	90964	90965	90966	95803	96360
96361	96373					

B. All 2009 CPT procedure codes listed in **Category II** and **Category III** are **non-covered.**

C. The following new 2009 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.

43273	61797	61799	61800	63621	96366
96367	96368	96370	96371	96372	96374
96375	96376				

D. Effective on and after March 1, 2009, the following currently payable procedure code has a **revised** description and is no longer payable to Outpatient Hospitals and Ambulatory Surgical Centers because this service is covered by another CPT procedure code, another HCPCS code or a revenue code.

63035

E. The following 2009 CPT procedure codes are not payable to Physicians because these services are covered by another CPT procedure code, another HCPCS code, or another revenue code.

96372 **99462**

F. The following 2009 CPT procedure code is not payable to Nurse Practitioners because this service is covered by another CPT procedure code, another HCPCS code or a revenue code.

99462

G. The following 2009 CPT procedure code is not payable to Certified Nurse Midwives because this service is covered by another CPT procedure code, another HCPCS code or a revenue code.

99462

III. Prior Authorization

The following 2009 CPT procedure code requires prior authorization from the Arkansas Foundation for Medical Care (AFMC).

65756

IV. CPT 2009 Procedure Codes That Require A Paper Claim with Appropriate Attachments

96379

V. Newborn Care Services (Initial Screening)

The 2009 CPT procedure codes for newborn care are listed below. These procedure codes represent the initial newborn screening. This screening includes the physical exam of the baby and the conference(s) with newborn's parent(s) and is considered to be the initial newborn care/screen. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes **99460**, **99461**, and **99463**.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

A. Physician Billing Instructions for Newborn Care

For ARKids A (EPSDT): Requires an EPSDT claim form or CMS 1500; may be billed electronically or on paper.

Procedure Code	Modifier # 1	Modifier # 2	Description
99460	EP	UA	Initial hospital/birthing center care, normal newborn (global)
99461	EP	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	EP	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

For ARKids First B: Requires CMS-1500 claim form; may be billed electronically or on paper.

Procedure Code	Modifier	Description
99460	UA	Initial hospital/birthing center care, normal newborn (global)
99461	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

B. <u>Nurse Practitioner and Certified Nurse Midwife Billing Instructions for Newborn Care</u>

For ARKids A (EPSDT) – Requires an EPSDT claim form or CMS 1500, may be billed electronically or on paper.

Procedure Code	Modifier	Description
99460	UA	Initial hospital/birthing center care, normal newborn (global)
99461	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

For ARKids First B – Requires a CMS-1500 claim form; may be billed electronically or on paper.

Procedure Code	Modifier	Description
99460	UA	Initial hospital/birthing center care, normal newborn (global)
99461	UA	Initial care normal newborn other than hospital/birthing center (global)
99463	UA	Initial hospital/birthing center care, normal newborn admitted/discharged same date of service (global)

VI. Existing Outpatient Procedure Codes:

Reimbursement of the following existing outpatient surgical procedure codes have been assigned to outpatient group IV.

22862	22857	22865

VII Podiatry Program

A. The following 2009 procedure codes are payable to Podiatrists:

20696	20697	64455	64632

B. The following existing procedure codes are now payable to Podiatrists:

14041	27685

VIII. Oral Surgeon Services

The following 2009 CPT procedure codes are payable to Oral Surgeons through the Physician program:

41512	41530	96365	96366	96367
96368	96374	96375	96379	

IX. Certified Nurse Midwife Program

The following 2009 CPT procedure codes are payable to Certified Nurse Midwives:

96365	96366	96367	96368	96369
96370	96371	96374	96375	96379
99460	96461	99463	99465	

X. Nurse Practitioner Program

The following 2009 CPT procedure codes are payable to Nurse Practitioners:

96365	96366	96367	96368	96369
96374	96375	96379	99460	99461
99463	99466	99467		

XI. CPT Procedure Codes Payable to Ambulatory Surgical Centers

The following 2009 CPT procedure codes are payable to ambulatory surgical centers:

20696	20697	22856	22861	22864	27027
27057	35535	35570	35632	35633	35634
41512	41530	43279	46930	49652	49653
49654	49655	49656	49657	55706	61796
61798	62267	63620	64455	64632	65756
77785	77786	77787	78808	83876	83951
85397	88720	88740	88741	93279	93280
93281	93282	93283	93284	93285	93286
93287	93288	93289	93290	93291	93292
93293	93294	93295	93296	93297	93298
93299	93306	93351	93352		

XII. Outpatient Hospitals

Use procedure code **96365** for IV therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code **0760** (for observation), up to 8 hours maximum per day.

XIII. 2009 CPT Lab Procedure Codes with Diagnosis Restrictions

The following 2009 CPT procedure codes will be payable with a primary diagnosis as is Indicated below.

Procedure Code	Required Primary Diagnosis
83951	571.5
88720	227.4, 774.2, 774.6, or 782.4
88740	986
88741	289.7 or 791.2

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 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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*****.**

Roy Jeffus

Roy Jeffus, Director

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OFFICIAL NOTICE

DMS-2009-AR-8	DMS-2009-A-13	DMS-2009-O-10	DMS-2009-E-4
DMS-2009-X-6	DMS-2009-II-14	DMS-2009-I-8	DMS-2009-L-14
DMS-2009-SS-7	DMS-2009-KK-13	DMS-2009-R-14	DMS-2009-S-7
DMS-2009-J-7			

TO: **Health Care Provider – 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, 2009**

SUBJECT: **2009 HCPCS Procedure Code Conversion**

I. General Information

A review of the 2009 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, 2009. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines, and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2009 HCPCS Level II will become non-payable for dates of service on and after March 1, 2009

II. 2009 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are 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 are devised for ease of reference.

II. 2009 HCPCS Payable Procedure Codes Tables Information (continued)

A. The first column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier based on the service performed.

B. 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" indicates that an item is not manually priced. Providers should consult their program manual to review the process involved in manual pricing.

C. 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 and hospitals. 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).

D. 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.)

E. 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.

F. 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.

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

H. 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 a paper claim when it is filed. Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments:

Process for Acquisition of Prior Approval Letter:

1. Before treatment begins, the Medical Director for the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in a provider manual or in official DMS correspondence. This requirement also applies to any drug, therapeutic agent or treatment with special instructions regarding coverage in a provider manual or official DMS correspondence.
2. The Medical Director's approval is necessary to insure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.
    a. The provider must submit a history and physical examination with the treatment protocol before beginning any treatment.

II. 2009 HCPCS Payable Procedure Codes Tables Information (continued)

b. The provider will be notified by mail of the DMS Medical Director's decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each paper claim submission.

Any change in approved treatment requires resubmission and a new approval letter.

c. Requests for a prior approval letter must be addressed to the attention of the Medical Director. Contact the Medical Director's office for any additional coverage information and instructions.

Mailing address:
Attention Medical Director
Division of Medical Services
AR Department of Human Services
PO Box 1437, Slot S412
Little Rock, AR 72203-1437

OR

FAX: 501-682-8013
PHONE: 501-682-9868

Please Note: The Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2009 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	Diagnosis List 029	Diagnosis List 030
042,	227.4	289.7
140.0 through 208.91	774.2	791.2
230.0 through 238.9	774.6	
511.81	782.4	
V58.11 through V58.12		
V87.41		

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

The following information is related to procedure codes found in the ASC table. For section IV, 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 list. In addition to the special circumstances listed below with each alpha character, any other processes or requirements indicated in the table are also applicable.

A Q4112, Q4113, Q4114

Each procedure code is manually reviewed and requires paper billing with an operative report attached that includes wound measurements.

2009 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)
C9356	Y				N	N		N
C9358	Y				N	N		N
C9359	Y				N	N		N
G0416	N				N	N		N
G0417	N				N	N		N
G0418	N				N	N		N
G0419	N				N	N		N
Q4101	N				N	N		N
Q4102	N				N	N		N
Q4103	N				N	N		N
Q4104	N				N	N		N
Q4105	N				N	N		N
Q4106	N				N	N		N
Q4107	N				N	N		N
Q4108	N				N	N		N
Q4110	N				N	N		N
Q4111	N				N	N		N
Q4112[A]	N				Y	N		N
Q4113[A]	N				Y	N		N
Q4114[A]	N				Y	N		N

V. HCPCS Procedure Codes Payable to Podiatrist

2009 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)
Q4101	N				N	N		N
Q4104	N				N	N		N
Q4105	N				N	N		N
Q4106	N				N	N		N
Q4108	N				N	N		N

VI. HCPCS Procedure Codes Payable to Prosthetics

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

Procedure codes in the table must be billed with appropriate modifiers. Modifier NU is indicated for beneficiaries 21 years of age and over. Modifier EP is indicated for beneficiaries under age 21 years of age.

For procedure codes that require a prior authorization, the written PA request must be obtained through the Utilization Review Section of the Division of Medical Services (DMS) for wheelchairs and wheelchair related equipment and services. For other durable medical equipment, a written request must be submitted to the Arkansas Foundation for Medical Care. Please refer to your Arkansas Medicaid Prosthetics Provider Manual for details in requesting a DME prior authorization.

2009 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)
E1354	Y				N	Y	NU	N
E2231	N				N	Y	NU	N
E2231	N				N	Y	EP	N
E2295	Y				N	Y	EP	N
K0672	N				N	N	NU	N
K0672	N				N	N	EP	N
L6711	N				N	Y	EP	N
L6712	N				N	Y	EP	N
L6713	N				N	Y	EP	N
L6714	N				N	Y	EP	N
L6721	N				N	Y	NU	N
L6722	N				N	Y	NU	N

VII. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes found in the hospital table. For section VII 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 list. Claims that require attachments (such as op-reports and prior approval letters) must be billed on a paper claim. See Section II of this notice for information on requesting a prior approval letter. See Section III of this notice for diagnosis codes contained in diagnosis list 003, 029 and 030.

In addition to the special circumstances listed below with each alpha character, any other processes or requirements indicated in the table are also applicable.

A. A9580

This procedure code is covered for beneficiaries with a primary diagnosis of 198.5. It requires a paper claim with a manufacturer's invoice identifying the cost of the radiopharmaceutical.

B. C9245

This procedure code is restricted to beneficiaries age 19 years and older. It requires a primary diagnosis of 287.31.

C. C9246

This procedure code is restricted to beneficiaries age 21 years and older.

D. J0641

This procedure code is payable for beneficiaries of all ages. It is restricted to a diagnosis code of 170.0 through 170.9. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim.

Approved Only:

1. After high methotrexate therapy in osteosarcoma or
2. To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.

See section II of this notice for instructions on requesting a prior approval letter.

E. J1459

This procedure code is restricted to beneficiaries age 16 years and older.

F. J1953

This procedure code is restricted to beneficiaries age 17 years and older.

G. J3101

This HCPCS procedure code replaces deleted procedure code **J3100**. **J3101** is payable for beneficiaries of all ages; for ages 21 years and above, a diagnosis code from List 003 or 410.00 through 410.92 is required.

H. J9033

This procedure code is restricted to beneficiaries age 21 years and older. It requires a primary diagnosis code of 200.30 through 200.48, 202.01 through 202.08, 202.8, 203.00, 203.10, 203.80, 204.10 through 204.12, or 238.6. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim. See section II of this notice for instructions on requesting a prior approval letter.

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

I. J9207

This procedure is restricted to beneficiaries age 21 years and above. It requires a diagnosis of 174.0 through 175.9. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim. See section II of this notice for instructions on requesting a prior approval letter.

J. J9330

This procedure code is restricted to beneficiaries age 21 years and older. It requires a diagnosis 189.0 through 189.1.

K. Q4112, Q4113, Q4114

Each of these procedure codes are manually reviewed and requires paper billing with an operative report that includes wound measurements.

2009 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List (See section III details)	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
A9580[A]	Y	198.5	198.5		N	N		N
C9245[B]	Y	287.31	287.31		N	N		N
C9246[C]	Y				N	N		N
C9247	Y				N	N		N
C9248	Y				N	N		N
C9356	Y				N	N		N
C9358	Y				N	N		N
C9359	Y				N	N		N
G0413	N				N	N		N
G0414	N				N	N		N
G0416	N				N	N		N
G0417	N				N	N		N
G0418	N				N	N		N
G0419	N				N	N		N
J0641[D]	N	170.0	170.9		N	N		Y
J1267	N			003	N	N		N
J1453	N			003	N	N		N
J1459[E]	N				N	N		N
J1750	N				N	N		N

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

2009 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List (See section III details)	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
J1930	N				N	N		N
J1953[F]	N				N	N		N
J3101[G]	N	410.00	410.92	003	N	N		N
J3300	N				N	N		N
J7186	N				N	N		N
J8705	N			003	N	N		N
J9033[H]	N	200.30 202.01 202.8 203.00 203.10 203.80 204.10 238.6	200.48 202.08 202.8 203.00 203.10 203.80 204.12 238.6		Y	N		Y
J9207[I]	N	174.0	175.9		Y	N		Y
J9330[J]	N	189.0	189.1		N	N		N
Q4101	N				N	N		N
Q4102	N				N	N		N
Q4103	N				N	N		N
Q4104	N				N	N		N
Q4105	N				N	N		N
Q4106	N				N	N		N
Q4107	N				N	N		N
Q4108	N				N	N		N
Q4110	N				N	N		N
Q4111	N				N	N		N
Q4112[K]	N				Y	N		N
Q4113[K]	N				Y	N		N

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

2009 Codes	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List (See section III details)	Review Y/N	PA Y/N	Modifier	Prior Approval Letter (Y/N)
Q4114[K]	N				Y	N		N
S2118	Y				N	N		N
S2270	Y			003	N	N		N
S3628	Y				N	N		N
S3860	Y				N	N		N
S3861	Y				N	N		N
S3862	Y				N	N		N

VIII. HCPCS Procedures Codes Payable to Independent Lab

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

2009 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)
G0416	N				N	N		N
G0417	N				N	N		N
G0418	N				N	N		N
G0419	N				N	N		N
S3628	Y				N	N		N
S3860	Y				N	N		N
S3861	Y				N	N		N
S3862	Y				N	N		N

IX. HCPCS Procedures Codes Payable to Independent Radiology

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

This procedure requires a paper claim with a manufacturer's invoice identifying the cost of the radiopharmaceutical.

2009 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)
A9580	Y	198.5	198.5		N	N		N

X. 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. For section X, reference the superscript alpha character following the procedure code in the table to determine what coverage protocol applies to that procedure code in the list. Claims that require attachments (such as operative reports and prior approval letters) must be billed on a paper claim. See section II of this notice for information on requesting a prior approval letter. See section III of this notice for diagnosis codes contained in diagnosis list 003, 029 and 030. In addition to the special circumstances listed below with each alpha character, any other processes or requirements indicated in the table are also applicable.

A. A9580

This procedure code is covered for beneficiaries with a primary diagnosis of 198.5. It requires a paper claim with a manufacturer's invoice identifying the cost of the radiopharmaceutical.

B. C9245

This procedure code is restricted to beneficiaries age 19 years and older. It requires a primary diagnosis of 287.31

C. C9246

This procedure code is restricted to beneficiaries age 21 years and older.

D. J0641

This procedure code is payable for beneficiaries of all ages. It is restricted to a diagnosis code of 170.0 through 170.9. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim.

Approved Only:

1. After high methotrexate therapy in osteosarcoma or
2. To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.

See section II of this notice for instructions on requesting a prior approval letter.

E. J1459

This procedure code is restricted to beneficiaries age 16 years and older.

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

F. J1953

This procedure code is restricted to beneficiaries age 17 years and older.

G. J9033

This procedure code is restricted to beneficiaries age 21 years and older. It requires a primary diagnosis code of 200.30 through 200.48, 202.01 through 202.08, 202.8, 203.00, 203.10, 203.80, 204.10 through 204.12 or 238.6. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim. See section II of this notice for instructions on requesting a prior approval letter.

H. J9207

This procedure code is restricted to beneficiaries age 21 years and older. It requires a primary diagnosis code of 174.0 through 175.9. A prior approval letter from the DMS Medical Director is required and a copy must be attached to each paper claim. See section II of this notice for instructions on requesting a prior approval letter.

I. J9330

This procedure code is restricted to beneficiaries age 21 years and older. It requires a diagnosis of 189.0 through 189.1.

2009 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)
A9580[A]	Y	198.5	198.5		N	N		N
C9245[B]	Y	287.31	287.31		N	N		N
C9246[C]	Y				N	N		N
C9247	Y				N	N		N
C9248	Y				N	N		N
G0413	N				N	N		N
G0414	N				N	N		N
G0416	N				N	N		N
G0417	N				N	N		N
G0418	N				N	N		N
G0419	N				N	N		N
J0641[D]	N	170.0	170.9		Y	N		Y
J1267	N			003	N	N		N
J1453	N			003	N	N		N
J1459[E]	N				N	N		N
J1750	N				N	N		N

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

J1930	N				N	N		N
J1953[F]	N				N	N		N
J3300	N				N	N		N
J7186	N				N	N		N
J8705	N			003	N	N		N
J9033[G]	N	200.30 202.01 202.8 203.00 203.10 203.80 204.10 238.6	200.48 202.08 202.8 203.00 203.10 203.80 204.12 238.6	003	Y	N		Y
J9207[H]	N	174.0	175.9		Y	N		Y
J9330[I]	N	189.0	189.1		N	N		N
Q4101	N				N	N		N
Q4102	N				N	N		N
Q4103	N				N	N		N
Q4104	N				N	N		N
Q4105	N				N	N		N
Q4106	N				N	N		N
Q4107	N				N	N		N
Q4108	N				N	N		N
S2118	Y				N	N		N
S2270	Y			003	N	N		N
S3628	Y				N	N		N
S3860	Y				N	N		N
S3861	Y				N	N		N
S3862	Y				N	N		N

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

2009 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)
J1750	N				N	N		N

XII. Non-Covered 2009 HCPCS with Elements of CPT or Other Procedure Codes

C8929	C8930	C9898	G0409	G0410	G0411	G0412	G0415
G8510	G8511	G8516	G8517	Q4109			

XIII. Non-Covered 2009 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A6545	A9284	C9899	E0487	E0656	E0657	E0770	E1356
E1357	E1358	E2230	G0398	G0399	G0400	G0402	G0403
G0404	G0405	G0406	G0407	G0408	G8485	G8486	G8487
G8488	G8489	G8490	G8491	G8492	G8493	G8494	G8495
G8496	G8497	G8498	G8499	G8500	G8501	G8502	G8503
G8504	G8505	G8506	G8507	G8508	G8509	G8512	G8513
G8514	G8515	G8518	G8519	G8520	G8521	G8522	G8523
G8524	G8525	G8526	G8527	G8528	G8529	G8530	G8531
G8532	G8533	G8534	G8535	G8536	G8537	G8538	G8539
G8540	G8541	G8542	G8543	G8544	J2785	J7606	L0113
L8604	Q4100	S3711	S9433				

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

2009 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)
J1750	N				N	N		N

XII. Non-Covered 2009 HCPCS with Elements of CPT or Other Procedure Codes

C8929	C8930	C9898	G0409	G0410	G0411	G0412	G0415
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E1357	E1358	E2230	G0398	G0399	G0400	G0402	G0403
G0404	G0405	G0406	G0407	G0408	G8485	G8486	G8487
G8488	G8489	G8490	G8491	G8492	G8493	G8494	G8495
G8496	G8497	G8498	G8499	G8500	G8501	G8502	G8503
G8504	G8505	G8506	G8507	G8508	G8509	G8512	G8513
G8514	G8515	G8518	G8519	G8520	G8521	G8522	G8523
G8524	G8525	G8526	G8527	G8528	G8529	G8530	G8531
G8532	G8533	G8534	G8535	G8536	G8537	G8538	G8539
G8540	G8541	G8542	G8543	G8544	J2785	J7606	L0113
L8604	Q4100	S3711	S9433				