



**Division of Medical Services
Program Development & Quality
Assurance**

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



OFFICIAL NOTICE

DMS-2010-A-4
DMS-2010-CA-1
DMS-2010-II-4
DMS-2010-R-4

DMS-2010-AR-3
DMS-2010-L-4
DMS-2010-QQ-1
DMS-2010-C1

DMS-2010-Z-1
DMS-2010-SS-1
DMS-2010-00-3
DMS-2010-G-3

DMS-2010-H-1
DMS-2010-KK-3

TO: Health Care Provider –AHECS, Ambulatory Surgical Center; ARKids First-B; Child Health Management Services (CHMS); Child Health Services (EPSDT); Critical Access Hospital; End Stage Renal Disease; Federally Qualified Health Center (FQHC); Hearing; Hospital; Independent Lab; Independent Radiology; Nurse Practitioner; Physician; Radiation Therapy Center; Rural Health Clinic (RHC); and Arkansas Department of Health.

DATE: March 29, 2010

SUBJECT: 2010 CPT Procedure Code Conversion

I. General Information

A review of the 2010 CPT procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT 2010 procedure codes for dates of service on and after March 29, 2010.

Procedure codes that are identified as deletions in CPT 2010 (Appendix B) are **non-payable** for dates of service on and after March 29, 2010.

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 2010 CPT and HCPCS conversions.

II. Non-Covered 2010 CPT Procedure Codes

- A. Effective for dates of service on and after March 29, 2010, the following CPT procedure codes are non-payable:

43775	83987	86305	89398
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- B. All 2010 CPT procedure codes listed in **Category II** and **Category III** are not recognized by Arkansas Medicaid; therefore they are non-covered.

- C. The following new 2010 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:

31627	36148	64491	64492	64494	64495	75791
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III. Prior Authorization

The following 2010 CPT procedure codes require prior authorization:

63661	63662	63663	63664
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IV. Coverage for CT Colonography

- A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

74261	74262	74263
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- B. CT colonography policy and billing

1. Virtual colonoscopy also known as CT colonography utilizes helical computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D and/or 3-D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy), and air insufflation to achieve colonic distention.

2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximally. Failure to advance the colonoscopy may be secondary to an obstruction neoplasm, spasm, redundant colon, diverticulitis extrinsic compression or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon proximal to the obstruction would be of use to the surgeons in planning the operative approach to the patient.
 3. Limitations:
 - a. Virtual colonography is not reimbursable when used for screening, or in the absence of signs of symptoms of disease, regardless of family history, or other risk factors for the development of colonic disease.
 - b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening or in the absence of signs or symptoms of disease.
 - c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (e.g. biopsy) or for treatment (e.g. polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.
 - d. CT colonography procedure codes are counted against the beneficiary's annual lab and x-ray benefit limit.
 - e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.
 - f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.
- C. Documentation requirements and utilization guidelines:
1. Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-9-CM codes coded to the highest level of specificity will be denied.
 2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography) which was incomplete must be retained in the patient's record.

3. The patient's medical record must include the following and be available upon request:
 - a. The order/prescription from the referring physician;
 - b. Description of polyps/lesion:
 - i. Lesion size [for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views. The type of view employed for measurement should be stated];
 - ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon, and cecum);
 - iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa); and
 - iv. Attenuation (soft-tissue attenuation or fat).
 - c. Global assessment of the colon (C-RADS categories of colorectal findings):
 - i. C0- Inadequate study
poor prep (can't exclude > 10 lesions)
 - ii. C1- Normal colon or benign lesions
no polyps or polyps ≥ 5 mm
benign lesions (lipomas, inverted diverticulum)
 - iii. C2- Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings
 - iv. C3- Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥ 10 mm
Polyps 6-9 mm in size, ≥ 3 in number
 - v. C4- Colonic mass, likely malignant.
 - d. Extracolonic findings (integral to the interpretation of CT colonography results)
 - i. E0-Inadequate Study limited by artifact
 - ii. E1-Normal exam or anatomic variant
 - iii. E2-Clinically unimportant findings (no work-up needed)
 - iv. E3-Likely unimportant findings (may need work-up)
incompletely characterized lesions
(e.g.) hypodense renal or liver lesion
 - v. E4-Clinically important findings (work-up needed)
(e.g.) solid renal or liver mass, aortic aneurysm, adenopathy
 - e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy which was incomplete due to obstruction.

D. Billing protocol for CT colonography procedure codes 74261, 74262, & 74263:

1. CT colonography codes in this notice are covered with a primary ICD-9-CM diagnosis of V64.3.
2. CT colonography is billable electronically or on paper claims.

V. Child Health Management Services (CHMS)

The following 2010 CPT procedure codes are payable to Child Health Management Services:

92550	92570
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VI. Hearing Program

The following 2010 CPT procedure codes are payable to Hearing Service Providers:

92540	92550	92570
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VII. Vaccines for Children (VFC)

The procedure code information below shows the coverage and billing protocol for VFC providers.

ARKids A	ARKids B	Ages
90670- EP, TJ Modifiers	90670- TJ Modifier	6 weeks to 5 years

VIII. CPT Procedure Codes Payable to Ambulatory Surgical Centers

The following 2010 CPT procedure codes are payable to Ambulatory Surgical Centers:

14301	21011	21012	21013	21014	21016
21552	21554	21558	21931	21932	21933
21936	22901	22902	22903	22904	22905
23071	23073	23078	24071	24073	24079
25071	25073	25078	26111	26113	26118
27043	27045	27059	27337	27339	27364
27616	27632	27634	28039	28041	28047

Official Notice

DMS-2010-A-4
DMS-2010-CA-1
DMS-2010-II-4
DMS-2010-R-4

DMS-2010-AR-3
DMS-2010-L-4
DMS-2010QQ-1
DMS-2010-C1

DMS-2010-Z-1
DMS-2010-SS-1
DMS-2010-00-3
DMS-2010-G-3

DMS-2010-H-1
DMS-2010-KK-3

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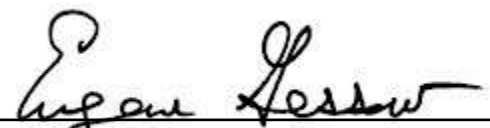
29581	31626	32552	32553	32561	32562
36147	37761	43281	43282	45171	45172
46707	49411	51727	51728	51729	53855
57426	63661	63662	63663	63664	64490
64493	74261	74262	74263	75565	75571
75572	75573	75574	78451	78452	78453
78454	84145	84431	86352	86825	86826
87150	87153	87493	88738	92550	92570
93750	94011	94012	94013	95905	

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.


Eugene I. Gessow, Director



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DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

TO: Health Care Provider – AHECS, Arkansas Department of Health, Ambulatory Surgical Center, ARKids First-B, Certified Nurse Midwife, Critical Access Hospital, End-Stage Renal Disease, Hemodialysis, Home Health, Hospital, Hyperalimentation, Independent Radiology, Nurse Practitioner, Physician, Private Duty Nursing, Prosthetics, Transportation

DATE: March 29, 2010

SUBJECT: 2010 HCPCS Procedure Code Conversion

I. General Information

A review of the 2010 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 29, 2010. 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 2010 HCPCS Level II will become non-payable for dates of service on and after March 29, 2010.

Please note: The Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2010 CPT and HCPCS conversions.

II. 2010 HCPCS Payable Procedure Codes Tables Information

A. 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 ten columns of information. All columns may not be applicable for each covered program, but are devised for ease of reference.

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

II. A. 2010 HCPCS Payable Procedure Codes Tables Information (continued)

Please note: An asterisk indicates that the procedure code requires a paper claim.

1. 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(s) based on the service performed.
2. The second column indicates any modifiers that must be used in conjunction with the procedure code, when billed, either electronically or on paper.
3. The third column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.
4. The fourth 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.
5. 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 fifth and sixth 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).
6. The seventh 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.)
7. The eighth 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.
8. The ninth 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.
9. The tenth 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.

II. 2010 HCPCS Payable Procedure Codes Tables Information (continued)

B. Acquisition of Prior Approval Letter:

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:

1. Process for Acquisition: 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 a prior approval letter indicated for coverage in a provider manual or official DMS correspondence.
2. The Medical Director's review 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 plan before beginning any treatment.
 - 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 OR AR Department of Human Services PO Box 1437, Slot S412 Little Rock, AR 72203-1437	Fax: 501-682-8013 Phone: 501-682-9868
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DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

II. 2010 HCPCS Payable Procedure Codes Tables Information (continued)

C. Process for Obtaining Prior Authorization:

1. When obtaining a prior authorization from the Arkansas Medicaid Utilization Review Section, please send your request to the following:

Telephone Toll free	1-800-482-5850, extension 2-8340
Telephone	(501) 682-8340
Fax	(501) 682-8013
Mailing address	Arkansas DHS Division of Medical Services Utilization Review Section P.O. Box 1437, Slot S413 Little Rock, AR 72203-1437

2. When a obtaining a prior authorization from the Arkansas Foundation for Medical Care, please send your request to the following:

In-state and out-of-state toll free for inpatient reviews only	1-800-426-2234
General telephone contact, local or long distance - Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649- 0776
Fax	(479) 649-0799
Mailing address	Arkansas Foundation for Medical Care, Inc PO Box 180001 Fort Smith, AR 72918-0001
Physical site location	2201 Brooken Hill Drive Fort Smith, AR 72908
Office hours	8 30 a.m. until 5 00 p.m. (Central Time), Monday through Friday, except holidays

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 is specified below. For any other diagnosis restrictions, reference the table for each individual program.

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

III. Diagnosis Range and Diagnosis Lists (continued)

Diagnosis List 003

042
140.0 through 209.30
209.31 through 209.36
209.70 through 209.75
209.79
230.0 through 238.9
511.81
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.

J7325^A Hyaluronon injections are covered for all ages. Prior authorization is required for coverage of the Hyaluronon injection for ASC providers. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code (J7325). (Current codes are J7321, J7323, J7324)

A written request must be submitted to the Division of Medical Services Utilization Review Section (See Section II,C.). The request must include the patient's name, Medicaid ID number, physicians' name, physician's Arkansas Medicaid provider number, patient's date of birth, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections per knee are allowed of Hylan polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures.

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

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A9581		21& up	N				N	N	N
A9604		21& up	Y			003	N	N	N
C9363		N	N	940.0	949.5		N	N	N
J7185		21-65	N				N	N	N
J7325 ^A		N	N				N	Y	N
Q4116		N	Y	174.0	174.9		N	N	N

V. HCPCS Procedure Codes Payable to ARKids First-B

- A. The following information is related to procedure codes payable to the ARKids First-B program.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
K0739	NU U1	0-18	N				N	N	N
K0739	NU U4	0-18	N				N	N	N
K0739*	NU	0-18	Y				N	N	N

B. ARKids First-B Crosswalk

The following table is a crosswalk for 2010 procedure code K0739 which replaces E1340.

The symbol ⚠(...) along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description. Any revision of the E1340 description is for clarification only.

V. B. HCPCS Procedure Codes Payable to ARKids First-B (continued)

Previous Procedure Code	Modifier	2010 Procedure Code	Modifier	Description
E1340	NU U1	K0739	NU U1	** (Durable Medical Equipment Repair labor only. a maximum of 20 units per date of service is allowed one unit =15 minutes of labor).
E1340	NU	K0739*	NU	** (Durable Medical Equipment parts only. Repairs/parts will not be approved for more than the allowed purchase price of new equipment. The manufacture's invoice for all parts must be attached to repair claim).
E1340	NU U4	K0739	NU U4	** (Maintenance for capped rental items)

VI. HCPCS Procedure Codes Payable to Certified Nurse Midwife

The following information is related to procedure codes payable to Certified Nurse Midwife providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
J0461		N	N			003	N	N	N
J0559		N	N			003	N	N	N

VII. End Stage Renal Disease

The following information is related to procedure codes payable to End Stage Renal Disease providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
Q0139		N	N	584.0	586.0	N	N	N	N

VIII. HCPCS Procedure Codes Payable to Home Health

The following information is related to procedure codes payable to Home Health providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A4456		N	N				N	N	N
A4466*		0-20	Y				N	Y	N

IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to hospital providers. For section IX, 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.

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

C9256^A Coverage of this procedure code is for ages 21 years and above in these diagnosis ranges: 363.20, 364.0 through 364.42, 378.9 and 446.7. A broad spectrum microbide should be given prior to the injection. The beneficiary must have failed conventional therapy such as oral medications for this drug to be approved. There must be documentation of why the beneficiary is a failure of treatment. The visual acuity must be documented and should show a decrease due to failure of treatment. There must be severe disease that could lead to blindness. The beneficiary must be under the care of an ophthalmologist who specializes in treatment of this condition.

A Prior approval letter from the DMS Medical Director is required and must be attached to each claim.

C9257^B Coverage of this procedure code is for ages 21 years and above with a diagnosis code of 362.02, 362.07, 362.16, 362.26, 362.29, 362.35, 362.52, 364.42 or 365.63. Documentation included with prior approval letter request must include Fluorescein angiogram or OCT, patient screen for conditions that would contraindicate the use of Avastin, and documentation of patient consent. A prior approval letter is required and must be attached to each claim.

IX. HCPCS Procedure Codes Payable to Hospitals (continued)

J0586^C Payable for beneficiaries of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis code billed on the claim.

J0718^D Arkansas Medicaid considers certolizumab pegol (Cimzia®) medically necessary for adult beneficiaries 18 years of age and above with:

Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms:

Diarrhea	Internal fistulae
Abdominal pain	Intestinal obstruction
Bleeding	Extra-intestinal manifestations
Weight loss	Arthritis
Perianal disease	Spondylitis

AND

Crohn's disease has remained active despite treatment with one of the following:

Corticosteroids

OR

6-mercaptopurine/azathioprine

Arkansas Medicaid considers certolizumab pegol, alone or in combination with methotrexate (MTX), medically necessary for the treatment of adult beneficiaries 18 years of age and above with moderately-to-severely active rheumatoid arthritis (RA) and considers certolizumab pegol experimental and investigational for all other indications.

A Prior Approval Letter from the DMS Medical Director is required to be attached to each claim.

J2562^E This procedure code is covered for ages 21 years and above and requires prior authorization by Arkansas Foundation for Medical Care (AFMC). Prior authorization will be provided by a telephone review. Approval is granted in conjunction with the use of granulocyte-colony stimulating factor to mobilize hematopoietic stem cells for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma. Applicants will only be considered for approval if a transplant has been approved by AFMC. There must be documentation of failure to mobilize cells with conventional therapy for consideration of this drug. The drug will only be approved for four doses, one daily times four days. The total dosage for the four days must be indicated at the time of the request.

IX. HCPCS Procedure Codes Payable to Hospitals (continued)

J2796^F This procedure code is payable for ages 19 years and above with a diagnosis of 287.31. Beneficiaries must have failed corticosteroids, immunoglobulins or have had a splenectomy. Beneficiaries must have thrombocytopenia and a clinical condition that causes increased risk of bleeding.

Romiplostim is not to be used to normalize platelet counts.

This procedure code may be billed electronically and on paper claims.

J7325^G Hyaluronon injections are covered for all ages. Prior authorization is required for coverage of the Hyaluronon injection for outpatient hospital providers. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code (J7325). (Current codes are J7321, J7323, J7324)

A written request must be submitted to the Division of Medical Services Utilization Review Section (See Section II, C.). The request must include the patient's name, Medicaid ID number, physicians' name, physician's Arkansas Medicaid provider number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections/per knee are allowed of Hylan polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures.

J9328^H Coverage of this procedure code is payable for ages 21 years and above and requires a diagnosis in the range of 191.0-191.9. The diagnosis must be for:

1. Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

2. As maintenance treatment for refractory anaplastic astrocytoma in patients who have disease progression on nitrosourea and procarbazine.

Prior Approval Letter from DMS Medical Director required to be attached to each claim.

DMS-2010-A-5
DMS-2010-CA-1
DMS-2010-L-5
DMS-2010-KK-4
DMS-2010-J-2

DMS-2010-AR-4
DMS-2010-Z-1
DMS-2010-M-1
DMS-2010-R-5
DMS-2010-T-1

DMS-2010-O-3
DMS-2010-ZZ-1
DMS-2010-I-1
DMS-2010-S-1

IX. HCPCS Procedure Codes Payable to Hospitals (continued)

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List (See section III details)	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A9581		21& up	N				N	N	N
A9582		N	N				N	N	N
A9604		21& up	Y			003	N	N	N
C9254		18 & up	Y				N	N	N
C9255		18 & up	N	295.00	295.95		N	N	N
C9256 ^{*A}		21& up	N				Y	N	Y
C9257 ^{*B}		21& up	N				Y	N	Y
C9363		N	N	940.0	949.5		N	N	N
J0461		N	N			003	N	N	N
J0559		N	N			003	N	N	N
J0586 ^C		N	N				Y	N	N
J0718 ^{*D}		18 & up	N				Y	N	Y
J0833		N	N				N	N	N
J0834		N	N				N	N	N
J2562 ^E		21 & up	N				N	Y	N
J2796 ^F		19 & up	N	287.31	287.31		N	N	N
J7185		21-65	N				N	N	N
J7325 ^G		N	N				N	Y	N
J9155		21& up	N			003	N	N	N
J9171		N	N			003	N	N	N
J9328 ^{*H}		21& up	N	191.0	191.9		Y	N	Y
Q0139		N	N	584.0	586.0		N	N	N
Q4116		N	Y	174.0	174.9		N	N	N

X. HCPSC Procedures Codes Payable to Hyperalimentation Providers

A. The following information is related to procedure codes payable to Hyperalimentation providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
K0739	U9	N	N				N	Y	N

B. Hyperalimentation Crosswalk

The following table is a cross walk for 2010 procedure code K0739 which replaces E1340.

The symbol **(...) along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description. Any revision of the E1340 description is for clarification only.

Previous Procedure Code	Modifier	2010 Procedure Code	Modifier	Description
E1340	U9	K0739	U9	** (Repair or non routine service for enteral nutrition infusion pump, requiring the skill of a technician, parts and labor).

XI. HCPSC Procedure Codes Payable to Independent Radiology

The following information is related to procedure codes payable to Independent Radiology Providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A9582		N	Y				N	N	N
A9604		21 & up	Y			003	N	N	N

XII. HCPSC Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers.

J0586^A Payable for beneficiaries of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis code billed.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
J0461		N	N			003	N	N	N
J0559		N	N			003	N	N	N
J0586 ^A		N	N				Y	N	N
J0833		N	N				N	N	N
J0834		N	N				N	N	N
J9171		N	N			003	N	N	N

XIII. HCPSC Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs)

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

C9256^A Coverage of this procedure code is for ages 21 years and above in these diagnosis ranges: 363.20, 364.0 through 364.42, 378.9 and 446.7. A broad spectrum microbide should be given prior to the injection. The beneficiary must have failed conventional therapy such as oral medications for this drug to be approved. There must be documentation of why the beneficiary is a failure of treatment. The visual acuity must be documented and should show a decrease due to failure of treatment. There must be severe disease that could lead to blindness. The beneficiary must be under the care of an ophthalmologist who specializes in treatment of this condition. A Prior approval letter from the DMS Medical Director is required and must be attached to each claim.

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

C9257^B Coverage of this procedure code is for ages 21 years and above with a diagnosis code of 362.02, 362.07, 362.16, 362.26, 362.29, 362.35, 362.52, 364.42 or 365.63. Documentation included with prior approval letter request must include Fluorescein angiogram or OCT, patient screen for conditions that would contraindicate the use of Avastin, and documentation of patient consent. A prior approval letter is required and must be attached to each claim.

J0586^C Payable for beneficiaries of all ages when medically necessary. Botox A is reviewed for medical necessity based on diagnosis code billed.

J0718^D Arkansas Medicaid considers certolizumab pegol (Cimzia®) medically necessary for beneficiaries aged 18 years of age and above with:
Moderately-to-severely active Crohn's disease as manifested by any of the following signs/symptoms:

Diarrhea	Internal fistulae
Abdominal pain	Intestinal obstruction
Bleeding	Extra-intestinal manifestations
Weight loss	arthritis
Perianal disease	spondylitis

AND

Crohn's disease has remained active despite treatment with one of the following:
corticosteroids

OR

6-mercaptopurine/azathioprine

Arkansas Medicaid considers certolizumab pegol, alone or in combination with methotrexate (MTX), medically necessary for the treatment of beneficiaries 18 years and above with moderately-to-severely active rheumatoid arthritis (RA) and considers certolizumab pegol experimental and investigational for all other indications.

A Prior Approval Letter from the DMS Medical Director is required to be attached to each claim.

J2562^E This procedure code is covered for ages 21 years and above and requires prior authorization by Arkansas Foundation for Medical Care (AFMC). Prior authorization will be provided by a telephone review. Approval is granted in conjunction with the use of granulocyte-colony stimulating factor to mobilize hematopoietic stem cells for collection and subsequent autologous transplantation in patients with non-Hodgkin's lymphoma and multiple myeloma. Applicants will only be considered for approval if a transplant has been approved by AFMC. There must be documentation of failure to mobilize cells with conventional therapy for consideration of this drug. The drug will only be approved for four doses; one daily, times four days. The total dosage for the four days must be indicated at the time of the request.

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

J2796^F This procedure code is payable for ages 19 years and above with a diagnosis of 287.31. Beneficiaries must have failed corticosteroids, immunoglobulins or have had a splenectomy. Beneficiaries must have thrombocytopenia and a clinical condition that causes increased risk of bleeding.

Romiplostim is not to be used to normalize platelet counts.

This procedure code can be billed electronically and on paper claims.

J7325^G Hyaluronon injections are covered for all ages. Prior authorization is required for coverage of the Hyaluronon injection in the physician's office. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code (J7325). (Current codes are J7321, J7323, J7324).

A written request must be submitted to the Division of Medical Services Utilization Review Section (See Section II, C.). The request must include the patient's name, Medicaid ID number, physicians' name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections per knee are allowed of Hylan polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures.

J9328^H Coverage of this procedure code is payable for ages 21 years and above and requires a diagnosis in the range of 191.0-191.9. The diagnosis must be for:

1. Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

2. As maintenance treatment for refractory anaplastic astrocytoma in patients who have disease progression on nitrosourea and procarbazine.

A Prior Approval Letter from the DMS Medical Director is required to be attached to each claim.

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

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A9581		21 & up	N				N	N	N
A9582		N	Y				N	N	N
A9604		21 & up	Y			003	N	N	N
C9254		18 & up	N				N	N	N
C9255		18 & up	N	295.00	295.95		N	N	N
C9256 * ^A		21 & up	N				Y	N	Y
C9257 * ^B		21 & up	N				Y	N	Y
C9363		N	N	940.00	949.5		N	N	N
J0461		N	N			003	N	N	N
J0559		N	N			003	N	N	N
J0586 ^C		N	N				Y	N	N
J0718 * ^D		18 & up	N				Y	N	Y
J0833		N	N				N	N	N
J0834		N	N				N	N	N
J2562 ^E		21 & up	N				N	Y	N
J2796 ^F		19 & up	N	287.31	287.31		N	N	N
J7185		21-65	N				N	N	N
J7325 ^G		N	N				N	Y	N
J9155		21& up	N			003	N	N	N
J9171		N	N			003	N	N	N
J9328* ^H		21& up	N	191.0	191.9		Y	N	Y
Q0139		N	N	584.0	586.0		N	N	N

B. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of 21 years through the Child Health Services (EPSDT) program when prescribed by a physician.

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

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

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or, a switch from a body worn, external sound processor to a behind-the-ear (BTE) model, or technological advances in hardware, are considered not medically necessary and will not be approved.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
L8627*	EP	0-20	Y				N	Y	N
L8628 *	EP	0-20	Y				N	Y	N
L8629*	EP	0-20	Y				N	Y	N

Speech Processor:

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

Personal FM Systems:

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e. educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems (procedure code V5273 for use with cochlear implant) that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

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

Replacement, Repair, Supplies:

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger, and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

Prior Authorization

A request for prior authorization of a medically necessary FM system (V5273 for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to Arkansas Foundation for Medical Care (AFMC) using **DMS-679-A** (see attached). All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization. Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for, and payment of services are subject to all terms, conditions, and limitations of the Arkansas Medicaid program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost, or damaged piece of equipment free-of-charge by the manufacturer.

Some cochlear implant parts have previously been covered services under an unlisted procedure code.

The table below contains new and existing HCPCS procedure codes of FM system for use with cochlear implant and replacement cochlear implant parts.

Please note: Coverage and billing requirements to the physician provider for cochlear device implantation is unchanged.

Billing and Reimbursement Protocol for FM system and replacement cochlear implant parts:

Procedure codes L8615-L8629 on the table above require paper claim submission with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. V5273 may be submitted electronically or on a paper claim form. Provider charges for an FM system that is meant to be used with a cochlear implant, (V5273) should reflect the retail price. Reimbursement of an FM system to be used with a cochlear implant, (V5273) will be at 68 percent of the retail price.

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

Procedure Code	Modifier	Procedure Code Description	Prior Authorization	PA Criteria	Units Allowed per date of service
L8615*	EP	Headset/headpiece for use with Cochlear implant device, replacement	Yes	1 per 3 years	2
L8616*	EP	Microphone for use with cochlear implant device, replacement	Yes	1 per year	2
L8617*	EP	Transmitting coil for use with cochlear implant device, replacement	Yes	1 per year	2
L8618*	EP	Transmitter cable for use with cochlear implant device, replacement	Yes	4 per 6 months	8
L8619*	EP	Cochlear implant external speech processor, and controller, integrated system, replacement	Yes	5 years	2
L8621*	EP	Zinc air battery for use with cochlear implant device replacement, eac	Yes	180 units per 6 months	360
L8622*	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each	Yes	180 units per 6 months	360
L8623*	EP	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Yes	1 (set of 2) per year Unilateral	2
L8624*	EP	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	Yes	1 set of 2 per year Unilateral	2
L8627*	EP	Cochlear implant, external speech processor, component, replacement	Yes	Prior Authorized when not under warranty	2
L8628*	EP	Cochlear implant, external controller component, replacement	Yes	Prior authorized when not under warranty	2
L8629*	EP	Transmitting coil and cable, integrated ,for use with cochlear implant device, replacement	Yes	1 per year	2
V5273	EP	Assistive listening device, for use with Cochlear implant	Yes	Prior Authorized when not covered through IDEA	1

XIV. HCPCS Procedure Codes Payable to Private Duty Nurses

The following information is related to procedure codes payable to Private Duty Nursing providers.

A4456^A Indicates the code is payable in the school setting.

2010 Codes	Modifiers	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A4456		N	N				N	N	N
A4456 ^A		0-20	N				N	N	N

XV. HCPSC Procedure Codes Payable to Prosthetics

- A. The following information is related to procedure codes payable to Prosthetics providers. 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 (DME), 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.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
A4456	NU	N	N				N	N	N
A4466*	NU	0-20	Y				N	Y	N
E1036	NU	21& up	N				N	Y	N
E1036	EP	0-20	N				N	Y	N
K0739	NU	21 & up	Y				N	N	N
K0739	NU U1	21 & up	N				N	N	N
K0739	NU U3	21 & up	Y				N	N	N
K0739	NU U4	N	N				N	N	N
K0739	EP U1	2-20	N				N	N	N
K0739	EP U2	0-20	N				N	Y	N
K0739	EP U3	2-20	Y				N	N	N
L2861*	EP	0-20	Y				N	Y	N
L3891*	EP	0-20	Y				N	Y	N
L8031	NU	21 & up	N				N	N	N
L8031	EP	0- 20	N				N	N	N
L8032	NU	21 & up	N				N	N	N
L8032	EP	0-20	N				N	N	N

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

XV. HCPCS Procedure Codes Payable to Prosthetics (continued)**B. Cochlear Implants**

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of 21 years through the Child Health Services (EPSDT) program when prescribed by a physician.

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or, a switch from a body worn, external sound processor to a behind-the-ear (BTE) model, or technological advances in hardware, are considered not medically necessary and will not be approved.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
L8627 *	EP	0-20	Y				N	Y	N
L8628 *	EP	0-20	Y				N	Y	N
L8629*	EP	0-20	Y				N	Y	N

Speech Processor:

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

Personal FM Systems:

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e. educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

DMS-2010-A-5	DMS-2010-AR-4	DMS-2010-O-3
DMS-2010-CA-1	DMS-2010-Z-1	DMS-2010-ZZ-1
DMS-2010-L-5	DMS-2010-M-1	DMS-2010-I-1
DMS-2010-KK-4	DMS-2010-R-5	DMS-2010-S-1
DMS-2010-J-2	DMS-2010-T-1	

XV. B. HCPCS Procedure Codes Payable to Prosthetics (continued)

A Request for Prior Authorization may be submitted for medically necessary FM systems (procedure code V5273 for use with cochlear implant) that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

Replacement, Repair, Supplies:

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger, and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

Prior Authorization

A request for prior authorization of a medically necessary FM system (V5273 for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to Arkansas Foundation for Medical Care (AFMC) using **DMS-679-A** (see attached). All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization.

Prior authorization does not guarantee payment for services, the amount of payment for services. Eligibility for, and payment of services are subject to all terms, conditions, and limitations of the Arkansas Medicaid program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost, or damaged piece of equipment free-of-charge by the manufacturer.

Some cochlear implant parts have previously been covered services under an unlisted procedure code.

The table below contains new and existing HCPCS procedure codes of FM system for use with cochlear implant and replacement of cochlear implant parts.

Please note: Coverage and billing requirements to the physician provider for cochlear device implantation is unchanged.

XV. B. HCPCS Procedure Codes Payable to Prosthetics (continued)**Billing and Reimbursement Protocol for FM system and replacement cochlear implant parts:**

Procedure codes L8615-L8629 on the table above require paper claim submission with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. V5273 may be submitted electronically or on a paper claim form. Provider charges for an FM system that is meant to be used with a cochlear implant, (V5273) should reflect the retail price. Reimbursement of an FM system to be used with a cochlear implant, (V5273) will be at 68 percent of the retail price.

Procedure Code	Modifier	Procedure Code Description	Prior Authorization	PA Criteria	Units Allowed per date of service
L8615*	EP	Headset/headpiece for use with Cochlear implant device, replacement	Yes	1 per 3 years	2
L8616*	EP	Microphone for use with cochlear implant device, replacement	Yes	1 per year	2
L8617*	EP	Transmitting coil for use with cochlear implant device, replacement	Yes	1 per year	2
L8618*	EP	Transmitter cable for use with cochlear implant device, replacement	Yes	4 per 6 months	8
L8619 *	EP	Cochlear implant external speech processor, and controller, integrated system, replacement	Yes	5 years	2
L8621*	EP	Zinc air battery for use with cochlear implant device replacement, each	Yes	180 units per 6 months	360
L8622*	EP	Alkaline battery for use with cochlear implant device, any size, replacement, each	Yes	180 units per 6 months	360
L8623*	EP	Lithium ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	Yes	1 (set of 2) per year Unilateral	2
L8624*	EP	Lithium ion battery for use with cochlear implant device speech processor, ear level, replacement, each	Yes	1 set of 2 per year Unilateral	2
L8627*	EP	Cochlear implant, external speech processor, component, replacement	Yes	Prior Authorized when not under warranty	2
L8628*	EP	Cochlear implant, external controller component, replacement	Yes	Prior authorized when not under warranty	2
L8629*	EP	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	Yes	1 per year	2
V5273	EP	Assistive listening device, for use with Cochlear implant	Yes	PA when not covered through IDEA	1

XV. HCPCS Procedure Codes Payable to Prosthetics (continued)**C. Crosswalk**

The following table is a crosswalk for 2010 procedure code K0739 which replaces E1340.

The symbol **(...) along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description. Any revision of the E1340 description is for clarification only.

Previous Procedure Code	Modifiers	2010 Procedure Code	Modifiers	Description
E1340	NU	K0739*	NU	** (DME Repair, Parts only. Repairs will not be approved for more than the allowed purchase price of new equipment. The manufacturer's invoice must be attached to the repair claim for all parts.)
E1340	NU U1	K0739	NU U1	** (Labor only, Repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable 20 units=5 hours of labor)
E1340	EP U1	K0739	EP U1	** (Labor only, Repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes. A maximum of twenty units per date of service is allowable 20 units=5 hours of labor)
E1340	EP U2	K0739	EP U2	** (Repair or non-routine service for enteral nutrition infusion pump, requiring the skill of a technician, parts and labor.)
E1340	NU U3	K0739	NU U3	** (Unlisted Repairs/Parts Only wheelchairs; applicable pages from the manufacturers catalog must be attached to the claim form. Repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.)
E1340	EP U3	K0739	EP U3	** (Unlisted Repairs/Parts Only wheelchairs; applicable pages from the manufacturers catalog must be attached to the claim form. Repair or non routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes.)
E1340	NU U4	K0739	NU U4	** (Maintenance for Capped Rental items)

XVI. HCPCS Procedures Codes Payable to Transportation Providers

The following information is related to procedure codes payable to Transportation providers.

2010 Codes	Modifier	Age Restriction	Manually Priced Y/N	Beginning Diagnosis Range	Ending Diagnosis Range	Diagnosis List	Review Y/N	PA Y/N	Prior Approval Letter (Y/N)
J0461		N	N			N	N	N	N

XVII. Non-Covered 2010 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2010 HCPC procedure codes are not payable because these services are covered by a CPT code, another HCPCS code, or a revenue code.

A4264	C9250	E0433	G0425	G0426	G0427	G0430	G0431
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XVIII. Non-Covered 2010 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A4336	A4360	A9583	C9360	C9361	C9362	C9364	G0420
G0421	G0422	G0423	G0424	G8545	G8546	G8547	G8548
G8549	G8550	G8551	G8552	G8553	G8556	G8557	G8558
G8559	G8560	G8561	G8562	G8563	G8564	G8565	G8566
G8567	G8568	G8569	G8570	G8571	G8572	G8573	G8574
G8575	G8576	G8577	G8578	G8579	G8580	G8581	G8582
G8583	G8584	G8585	G8586	G8587	G8588	G8589	G8590
G8591	G8592	G8593	G8594	G8595	G8596	G8597	G8598
G8599	G8600	G8601	G8602	G8603	G8604	G8605	G8606
G8607	G8608	G8609	G8610	G8611	G8612	G8613	G8614
G8615	G8616	G8617	G8618	G8619	G8620	G8621	G8622
G8623	G8624	G8625	G8626	G8627	G8628	G9142	G9143
J0598	J1680	J2793	K0740	L5973	L8692	Q0138	Q0506
Q4074	Q4115	Q9968	S0280	S0281	S3713	S3865	
S3870							

Official Notice

DMS-2010-A-5

DMS-2010-AR-4

DMS-2010-O-3

DMS-2010-CA-1

DMS-2010-Z-1

DMS-2010-ZZ-1

DMS-2010-L-5

DMS-2010-M-1

DMS-2010-I-1

DMS-2010-KK-4

DMS-2010-R-5

DMS-2010-S-1

DMS-2010-J-2

DMS-2010-T-1

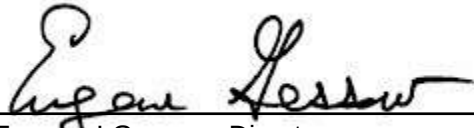
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Thank you for your participation in the Arkansas Medicaid Program.

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.



Eugene I Gessow, Director

**Division of Medical Services
Prescription & Prior Authorization Request for Medical Equipment
EXCLUDING Wheelchairs & Wheelchair Components**

SECTION A - TO BE COMPLETED BY THE PROVIDER					
☐ INITIAL ☐ RECERT ☐ MODIFICATION ☐ EXT OF BENEFITS				START DATE:	
PROVIDER NAME:				PROVIDER MAILING ADDRESS:	
PROVIDER IDENTIFICATION #/TAXONOMY CODE:				PROVIDER PHONE & CONTACT PERSON:	
BENEFICIARY NAME: (LAST, FIRST, MI)				BENEFICIARY MEDICAID ID #:	
BENEFICIARY MAILING ADDRESS:				DATE of BIRTH:	SEX: ☐ MALE ☐ FEMALE
PRESCRIBING PHYSICIAN:				PROVIDER IDENTIFICATION #/TAXONOMY CODE:	
PROCEDURE CODE	MOD 1	MOD 2	TOS	DESCRIPTION OF ITEMS REQUESTED	UNITS REQUESTED
Sample					
I attest that the above information is true to the best of my knowledge.					
_____ PROVIDER SIGNATURE				_____ DATE	
SECTION B - TO BE COMPLETED BY THE PHYSICIAN					
EST. LENGTH OF NEED: ____ WKS ____ MONTHS ____ PERM		EPSDT REFERRAL: ☐ YES ☐ NO ☐ N/A		CURRENT HEIGHT: ____ INCHES	CURRENT WEIGHT: ____ LBS
DIAGNOSIS & ICD-9 CODE:		DIAGNOSIS & ICD-9 CODE:		DIAGNOSIS & ICD-9 CODE:	
IS THIS EQUIPMENT BEING SUPPLIED FOR USE IN THE BENEFICIARY'S HOME? ☐ YES ☐ NO					
MEDICAL NECESSITY FOR REQUESTED SERVICES:					
_____ PHYSICIAN SIGNATURE				_____ DATE	

****A prescription for the requested items MUST be documented above or a separate prescription MUST be submitted. If the above documentation is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required. Please retain a copy of this form in your files.**

Send completed form to:
Arkansas Foundation for Medical Care, Inc., (AFMC) – Attn: Ami Winters
PO Box 180001
Fort Smith, AR 72918-0001

Instructions for Completion of Prior Authorization Request for Medical Equipment Form

SECTION A - TO BE COMPLETED BY THE PROVIDER

REVIEW TYPE:	Indicate the type of prior authorization request: initial, recertification, modification to a current authorization, or extension of benefits.
DATE(S) OF SERVICE REQUESTED:	Enter the requested date(s) of service.
PROVIDER INFORMATION:	Enter the provider name, address, provider identification number and taxonomy code, telephone number, and contact person.
PATIENT INFORMATION:	Enter the beneficiary's full name (Last, First, MI), ten-(10) digit Medicaid ID number, mailing address, date of birth (MM/DD/YYYY), and sex (male or female).
PHYSICIAN INFORMATION:	Enter the prescribing physician's name, provider identification number, and taxonomy code.
PROCEDURE CODES:	List all procedure codes (including any modifier or type of service if applicable) for items ordered that require authorization. (Procedure codes that do not require authorization should not be listed.) Enter the number of units requested and a narrative description for each item ordered.
PERSON SUBMITTING REQUEST:	The person submitting the request must sign and date, verifying the attestation in this section.

SECTION B - TO BE COMPLETED BY THE PHYSICIAN

EST. LENGTH OF NEED:	Enter the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of weeks or months or indicate permanent if the physician expects that the patient will require the item for the duration of his/her life.
EPSDT REFERRAL:	If applicable, indicate if the request is being made as the result of an EPSDT referral.
HEIGHT & WEIGHT:	Enter the beneficiary's current height measured in inches and weight measured in pounds.
DIAGNOSIS & ICD-9 CODES:	In the first space, list the diagnosis & ICD9 code that represents the primary reason for ordering this item. List any additional diagnosis & ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	Answer the question by checking the appropriate "YES" or "NO" box.
MEDICAL NECESSITY:	The physician must document medical necessity for the requested services and sign/date in the space indicated. Signature and date stamps are not acceptable.
**PRESCRIPTION:	A written prescription MUST be submitted with all requests. This can be documented on the request form or a separate prescription may be attached.
**LETTER OF MEDICAL NECESSITY:	If the information provided on the request form is insufficient to justify the requested items, a letter of medical necessity from the prescribing physician WILL be required.