ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

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

DATE: **March 15, 2011**

SUBJECT: **2011 Current Procedure Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2011 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT 2011 procedure codes for dates of service on and after March 15, 2011.

Procedure codes that are identified as deletions in CPT 2011 (Appendix B) are **non-payable** for dates of service on and after March 15, 2011.

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 2011 CPT and Healthcare Common Procedural Coding System Level II (HCPCS) conversions.

II. Non-Covered 2011 CPT Procedure Codes

A. Effective for dates of service on and after March 15, 2011, the following CPT procedure codes are non-covered.

64566	90644	90654	90664	90666	90667	90668	90867
90868	95800	95801	99224	99225	99226		

B. All 2011 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 2011 CPT procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

11045	11046	11047	22552	37222	37223	37232	37233
37234	37235	38900	43283	43338	49327	49412	61781
61782	61783	90460	90461	90470	92227	92228	93462
93463	93563	93564	93565	93566	93567	93568	

D. The following new 2011 CPT procedure codes are not payable to Ambulatory Surgical Centers because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

11045	11046	11047	22552	37222	37223	37232	37233
37234	37235	38900	43283	43338	49327	49412	61781
61782	61783	90460	90461	90470	92227	92228	

E. The following new 2011 CPT procedure codes are not payable to Physicians because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

90460	90461	90470	92227	92228

F. The following new 2011 CPT procedure codes are not payable to Vision Service Providers because these services are covered by another CPT procedure code, another HCPCS code or a revenue code.

92227	92228

III. Prior Authorization

When 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, prior authorizations for surgical procedures and assistant surgeons 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	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

The following 2011 CPT procedure codes require prior authorization from AFMC.

64568	64569	64570

IV. 2011 CPT Lab Procedure Codes with International Classification of Diseases, 9th Revision, and Clinical Modification (ICD-9-CM) Diagnosis Restrictions

The following 2011 CPT procedure codes will be payable with a primary (ICD-9-CM) diagnosis as is indicated below.

Procedure Code	Required Primary (ICD-9-CM) Diagnosis
87906	042

V. Independent Radiology

The following 2011 CPT procedure codes are payable to Independent Radiology Providers.

74176	74177	74178	76881	76882

VI. Oral Surgeons

The following 2011 CPT procedure codes are payable to Oral Surgeons.

31295	31296	31297

VII. Vision Program

The following 2011 CPT procedure codes are payable to Vision Service Providers.

92132	92133	92134

VIII. Ambulatory Surgical Centers

The following 2011 CPT procedure codes are payable to Ambulatory Surgical Centers.

29914	29915	29916	31295	31296	31297
31634	43753	43754	43755	43756	43757
49418	53860	64568	64569	64570	64611
65778	65779	66174	66175	74176	74177
74178	76881	76882	80104	82930	83861
84112	85598	86481	86902	87501	87502
87503	88120	88121	88177	88363	88749
91013	91117	92132	92133	92134	

If you have questions regarding this notice, please contact the HP Enterprise Services Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Thank you for your participation in the Arkansas Medicaid Program.

Eugene I. Gessow, Director

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OFFICIAL NOTICE

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

DATE: **March 15, 2011**

SUBJECT: **2011 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion**

I. General Information

A review of the 2011 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedural Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after March 15, 2011. 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 2011 HCPCS Level II will become non-payable for dates of service on and after March 15, 2011.

Please note: The Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2011 CPT and HCPCS conversions.

II. 2011 HCPCS Payable Procedure Codes Tables Information

A. Procedure codes are in separate tables. Tables are created for each affected provider type (i.e. 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.

II. 2011 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 ICD-9-CM 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 ICD-9-CM diagnoses for which a procedure code may be used, (i.e.: 053.0 through 054.9).

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 for Clinical Affairs for the Division of Medical Services. 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. 2011 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 Clinical Affairs in 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 for Clinical Affairs' review is necessary to ensure 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 for Clinical Affairs' 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 for Clinical Affairs. Contact the Medical Director for Clinical Affairs' office for any additional coverage information and instructions.

Mailing address: Attention Medical Director for Clinical Affairs 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

II. 2011 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 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, prior authorizations for surgical procedures and assistant surgeons 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	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4 30 p.m. (Central Time), Monday through Friday, except holidays

III. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. Diagnosis list 003 is specified below. For any other diagnosis restrictions, reference the table for each individual program.

III. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), 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 payable to the ASC Program.

2011 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)
C8931		N	Y				N	N	N
C8932		N	Y				N	N	N
C8934		N	Y				N	N	N
C8935		N	Y				N	N	N
C8936		N	Y				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.

2011 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)
E2622	NU	0-18	N				N	N	N
E2623	NU	0-18	N				N	N	N
E2624	NU	0-18	N				N	N	N
E2625	NU	0-18	N				N	N	N

VI. HCPCS Procedure Codes Payable to Certified Nurse Midwife

The following information is related to procedure codes payable to the Certified Nurse Midwife Program. See Section III of this notice for ICD-9-CM diagnosis codes contained in diagnosis list 003.

2011 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)
J0558		N	N			List 003	N	N	N
J0561		N	N			List 003	N	N	N

VII. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to hospital providers. 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 **ICD-9-CM** 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.

C9272[A] Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis, (ICD-9-CM 733.1). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for **Prolia.**

Note: Arkansas Medicaid requires that **Xgeva** be filed under J3590 on a paper claim with the drug name and dose. **Xgeva** is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. **Xgeva** is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. **Xgeva** requires documentation in the medical record of the rationale for why **Zometa** was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record.

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

C9277[B] Payable for beneficiaries aged 8 and older who have the ICD-9-CM detail diagnosis of 271.0. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe's disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme Alglucosidase Alfa Control (ACE) Program. The history and physical should document compliance with this program including discussion of the risks of anaphylaxis, severe allergic reactions and immune-mediated reactions according to the Black Box warning from the Food and Drug Administration. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability. The approval letter must be attached to each claim. (See Section 272.103 of the hospital manual or Section II B. of this notice for instructions for obtaining a prior approval letter.) Use this procedure code for **Lumizyme**.

C9278[C] Payable for beneficiaries ages 18 and older when medically necessary. This drug is reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.

J0597[D] Payable for beneficiaries ages 13 and older. This drug will be considered for claims with a primary ICD-9-CM diagnosis of 277.6 and will be reviewed for medical necessity based on the clinical documentation submitted.

J1290[E] Payable for beneficiaries ages 16 and older. This drug will be considered for claims with a primary ICD-9-CM diagnosis of 277.6 and will be reviewed for medical necessity based on the clinical documentation submitted.

J1599[F] Claims are reviewed for medical necessity, based on the ICD-9-CM diagnosis code billed.

J3262[G] This procedure code is only approved for rheumatoid arthritis, (ICD-9-CM 714.0) in adult patients ages 18 years and older. A prior approval letter is required. The patient must have tried and failed therapy with documented progression of symptoms on Humira and Enbrel prior to the request for this drug. The physician medical record must document a history and physical examination that clearly shows failure of Humira and Enbrel with submission for a prior approval letter. Doses exceeding 800 mg. per infusion will not be approved, as they are not recommended. The physician must follow all Food and Drug Administration (FDA) recommendations on monitoring of laboratory and serious infections. This procedure must be billed on a paper claim. (See Section 272.103 of the hospital manual or Section II B. of this notice for instructions for obtaining a prior approval letter). The prior approval letter must be submitted with each claim.

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

J3357[H] This procedure code is covered for the diagnosis of moderate to severe plaque psoriasis (ICD-9-CM 696.1) in adult patients ages 18 years and older. A prior approval letter is required. There must be clear documentation that the patient has failed Humira and Enbrel, with documentation of progression of the disease or documented inability to tolerate Humira and Enbrel. A physician history and physical must be submitted with a request for prior approval letter. Documentation of patient counseling of the adverse effects of the drug should also be included. This drug should only be administered to patients who will be closely monitored and have regular follow-up visits by a physician. This procedure must be billed on a paper claim. (See Section 272.103 of the hospital manual or Section II B. of this notice for instructions for obtaining a prior approval letter). The prior approval letter must be submitted with each claim.

J3385[I] This procedure code is for pediatric and adult beneficiaries ages 4 years and older with Type I Gaucher Disease (ICD-9-CM 272.7) who are symptomatic and require enzyme replacement therapy. This drug requires prior approval by the Medical Director for Clinical Affairs. A history and physical exam by a geneticist is required yearly for approval. The history and physical exam should document the prognosis of the patient as well as current symptoms. (See Section 272.103 of the hospital manual or Section II B. of this notice for instructions for obtaining a prior approval letter). This procedure must be billed on a paper claim. The prior approval letter must be attached to each claim.

J7312[J] This procedure code is covered for adults 18 years and older for the diagnosis of macular edema following branch retinal vein occlusion (BRVO), (ICD-9-CM 362.30), or central retinal vein occlusion (CRVO), (ICD-9-CM 362.35) and non-infectious uveitis of the posterior segment, (ICD-9-CM 363.20) which has failed oral treatments and is untreatable by any other method. This procedure code requires a prior approval letter. There should be documentation of vein occlusion and studies documenting macular edema. Visual acuity should be noted after the vein occlusion or after failed treatments for uveitis. The patients should be monitored after the injection for elevation in intraocular pressure and endophthalmitis. Counseling of side effects should be documented in the medical record. The history and physical exam including all tests should be sent with the request for prior approval letter. (See Section 272.103 of the hospital manual or Section II B. of this notice for instructions for obtaining a prior approval letter). This procedure must be billed on a paper claim. The prior approval letter must be attached to each claim.

VII. HCPCS Procedure Codes Payable to Hospitals (continued)

2011 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)
C8931		N	Y				N	N	N
C8932		N	Y				N	N	N
C8934		N	Y				N	N	N
C8935		N	Y				N	N	N
C8936		N	Y				N	N	N
C9270		18 & up	Y	279.00	279.09		N	N	N
C9272[A]		18 & up	Y	733.01	733.01		N	N	N
C9274		N	Y				N	N	N
C9277[B]*		8 & up	Y	271.0	271.0		Y	N	Y
C9278[C]		18 & up	Y				Y	N	N
C9279		N	Y			List 003	N	N	N
J0171		N	N				N	N	N
J0558		N	N			List 003	N	N	N
J0561		N	N			List 003	N	N	N
J0597[D]*		13 & up	N	277.6	277.6		Y	N	N
J0638		4 & up	N	277.31	277.31		N	N	N
J1290[E]*		16 & up	N	277.6	277.6		Y	N	N
J1559		4 & up	N	279.3	279.3		N	N	N
J1599[F]		4 & up	Y				Y	N	N
J1786		2 & up	N	272.7	272.7		N	N	N
J2358		18 & up	N			List 003	N	N	N
J2426		18 & up	N			List 003	N	N	N
J3095		18 & up	N			List 003	N	N	N
J3262[G]*		18 & up	N	714.0	714.0		Y	N	Y
J3357[H]*		18 & up	N	696.1	696.1		Y	N	Y
J3385[I]		4 & up	N	272.7	272.7		Y	N	Y
J7184		10 & up	N	276.4	276.4		N	N	N
J7196		18 & up	Y	286.5	286.5		N	N	N
J7312[J]*		18 & up	N			362.30 362.35 363.20	Y	N	Y
J9307		18 & up	N			List 003	N	N	N
J9315		18 & up	N			List 003	N	N	N
J9351		18 & up	N			List 003	N	N	N

*Denotes paper claim.

VIII. HCPC Procedure Codes Payable to Independent Radiology

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

2011 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)
C8931		N	Y				N	N	N
C8932		N	Y				N	N	N
C8934		N	Y				N	N	N
C8935		N	Y				N	N	N
C8936		N	Y				N	N	N

IX. HCPCS Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers. See Section III of this notice for **ICD-9-CM** diagnosis codes contained in diagnosis list 003.

2011 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)
J0171		N	N				N	N	N
J0558		N	N			List 003	N	N	N
J0561		N	N			List 003	N	N	N
J1559		4 & up	N	279.3	279.3		N	N	N
J1786		2 & up	N	272.7	272.7		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 using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) 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.

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

C9272[A] Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis, (ICD-9-CM 733.1). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for **Prolia.**

Note: Arkansas Medicaid requires that **Xgeva** be filed under J3590 on a paper claim with the drug name and dose. **Xgeva** is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. **Xgeva** is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. **Xgeva** requires documentation in the medical record of the rationale for why **Zometa** was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record.

C9277[B] Payable for beneficiaries aged 8 and older who have a primary ICD-9-CM diagnosis of 271.0. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe's disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme Alglucosidase Alfa Control (ACE) Program. The history and physical should document compliance with this program including discussion of the risks of anaphylaxis, severe allergic reactions and immune-mediated reactions according the Black Box warning from the Food and Drug Administration. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability. The approval letter must be attached to each claim. (See Section 244.100 of the physician manual or Section II B. of this notice for instructions for obtaining a prior approval letter.) Use this procedure code for **Lumizyme**.

C9278[C] Payable for beneficiaries ages 18 and older when medically necessary. This drug is reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.

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

J0597[D] Payable for beneficiaries ages 13 and older. This drug will be considered for claims with a primary ICD-9-CM diagnosis of 277.6 and will be reviewed for medical necessity based on the clinical documentation submitted.

J1290[E] Payable for beneficiaries ages 16 and older. This drug will be considered for claims with a primary ICD-9-CM diagnosis of 277.6 and will be reviewed for medical necessity based on the clinical documentation submitted.

J1599[F] Claims are reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.

J3262[G] This procedure code is only approved for rheumatoid arthritis, (ICD-9-CM 714.0) in adult patients ages 18 years and older. A prior approval letter is required. The patient must have tried and failed therapy with documented progression of symptoms on Humira and Enbrel prior to the request for this drug. The physician medical record must document a history and physical examination that clearly shows failure of Humira and Enbrel with submission for a prior approval letter. Doses exceeding 800 mg. per infusion will not be approved, as they are not recommended. The physician must follow all Food and Drug Administration (FDA) recommendations on monitoring of laboratory and serious infections. This procedure must be billed on a paper claim. (See Section 244.100 of the physician manual or Section II B. of this notice for instructions for obtaining a prior approval letter). The prior approval letter must be submitted with each claim.

J3357[H] This procedure code is covered for the diagnosis of moderate to severe plaque psoriasis (ICD-9-CM 696.1) in adult patients ages 18 years and older. A prior approval letter is required. There must be clear documentation that the patient has failed Humira and Enbrel, with documentation of progression of the disease or documented inability to tolerate Humira and Enbrel. A physician history and physical must be submitted with a request for prior approval letter. Documentation of patient counseling of the adverse effects of the drug should also be included. This drug should only be administered to patients who will be closely monitored and have regular follow-up visits by a physician. This procedure must be billed on a paper claim. (See Section 244.100 of the physician manual or Section II B. of this notice for instructions for obtaining a prior approval letter). The prior approval letter must be submitted with each claim.

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

J3385[I] This procedure code is for pediatric and adult beneficiaries ages 4 years and older with Type I Gaucher Disease (ICD-9-CM 272.7) who are symptomatic and require enzyme replacement therapy. This drug requires prior approval by the Medical Director for Clinical Affairs. A history and physical exam by a geneticist is required yearly for approval. The history and physical exam should document the prognosis of the patient as well as current symptoms. (See Section 244.100 of the physician manual or Section II B. of this notice for instructions for obtaining a prior approval letter). This procedure must be billed on a paper claim. The prior approval letter must be attached to each claim.

J7312[J] This procedure code is covered for adults ages 18 years and older for the diagnosis of macular edema following branch retinal vein occlusion (BRVO), (ICD-9-CM 362.30), or central retinal vein occlusion (CRVO), (ICD-9-CM 362.35) and non-infectious uveitis of the posterior segment, (ICD-9-CM 363.20) which has failed oral treatments and is untreatable by any other method. This procedure code requires a prior approval letter. There should be documentation of vein occlusion and studies documenting macular edema. Visual acuity should be noted after the vein occlusion or after failed treatments for uveitis. The patients should be monitored after the injection for elevation in intraocular pressure and endophthalmitis. Counseling of side effects should be documented in the medical record. The history and physical exam including all tests should be sent with the request for prior approval letter. (See Section 244.100 of the physician manual or Section II B. of this notice for instructions for obtaining a prior approval letter). This procedure must be billed on a paper claim. The prior approval letter must be attached to each claim.

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

2011 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)
C8931		N	Y				N	N	N
C8932		N	Y				N	N	N
C8934		N	Y				N	N	N
C8935		N	Y				N	N	N
C8936		N	Y				N	N	N
C9270		18 & up	Y	279.00	279.09		N	N	N
C9272[A]		18 & up	Y	733.01	733.01		N	N	N
C9274		N	Y				N	N	N
C9277[B]*		8 & up	Y	271.0	271.0		Y	N	Y
C9278[C]		18 & up	Y				Y	N	N
C9279		N	Y			List 003	N	N	N
J0171		N	N				N	N	N
J0558		N	N			List 003	N	N	N
J0561		N	N			List 003	N	N	N
J0597[D]*		13 & up	N	277.6	277.6		Y	N	N
J0638		4 & up	N	277.31	277.31		N	N	N
J1290[E]*		16 & up	N	277.6	277.6		Y	N	N
J1559		4 & up	N	279.3	279.3		N	N	N
J1599[F]		4 & up	Y				Y	N	N
J1786		2 & up	N	272.7	272.7		N	N	N
J2358		18 & up	N			List 003	N	N	N
J2426		18 & up	N			List 003	N	N	N
J3095		18 & up	N			List 003	N	N	N
J3262[G]*		18 & up	N	714.0	714.0		Y	N	Y
J3357[H]*		18 & up	N	696.1	696.1		Y	N	Y
J3385[I]		4 & up	N	272.7	272.7		Y	N	Y
J7184		10 & up	N	276.4	276.4		N	N	N
J7196		18 & up	Y	286.5	286.5		N	N	N
J7312[J]*		18 & up	N			362.30 362.35 363.20	Y	N	Y
J9307		18 & up	N			List 003	N	N	N
J9315		18 & up	N			List 003	N	N	N
J9351		18 & up	N			List 003	N	N	N

*Denotes paper claim

XI. HCPCS 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. The UE modifier signifies used equipment.

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.

2011 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)
A4566	NU	21 & up	Y				N	N	N
A4566	EP	2-20	Y				N	N	N
A7020	NU	21 & up	Y				N	Y	N
A7020	EP	0-20	Y				N	Y	N
E2622	NU	21 & up	N				N	N	N
E2622	EP	0-20	N				N	N	N
E2622	UE	N	N				N	N	N
E2623	NU	21 & up	N				N	N	N
E2623	EP	0-20	N				N	N	N
E2623	UE	N	N				N	N	N
E2624	NU	21 & up	N				N	N	N
E2624	EP	0-20	N				N	N	N
E2624	UE	N	N				N	N	N
E2625	NU	21 & up	N				N	N	N
E2625	EP	0-20	N				N	N	N
E2625	UE	N	N				N	N	N
L3674	NU	21 & up	N				N	N	N
L3674	EP	0-20	N				N	N	N
L4631	NU	21 & up	N				N	N	N
L4631	EP	0-20	N				N	N	N
L5961	NU	21 & up	Y				N	N	N
L5961	EP	0-20	Y				N	N	N
L8693	EP	0-20	Y				N	Y	N

XII. HCPCS Procedure Codes Payable to Transportation

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

2011 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)
J0171		N	N			N	N	N	N

XIII. Non-Covered 2011 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2011 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code or a revenue code.

C8933	C9367	G0434	J7309	Q0478	Q0479	Q2035	Q2036
Q2037	Q2038	Q2039	Q4117	Q4118	Q4119	Q4120	Q4121
Q5010							

XIV. Non-Covered 2011 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A9273	C1749	C9273	C9275	C9276	C9800	E0446	E1831
G0157	G0158	G0159	G0160	G0161	G0162	G0163	G0164
G0428	G0429	G0432	G0433	G0435	G0436	G0437	G0438
G0439	G0440	G0441	G8629	G8630	G8631	G8632	G8633
G8634	G8635	G8636	G8637	G8638	G8639	G8640	G8641
G8642	G8643	G8644	G8645	G8646	G8647	G8648	G8649
G8650	G8651	G8652	G8653	G8654	G8655	G8656	G8657
G8658	G8659	G8660	G8661	G8662	G8663	G8664	G8665
G8666	G8667	G8668	G8669	G8670	G8671	G8672	G8673
G8674	G8675	G8676	G8677	G8678	G8679	G8680	G8681
G8682	G8683	G8684	G8685	G8686	G8687	G8688	G8689
G8690	G8691	G8692	G8693	G9147	J0775	J1826	J7335
J7686	J8562	J9302	S0148	S0169	T1505		

XV. Modification to the Healthcare Common Procedure Coding System (HCPCS)

The Centers for Medicare and Medicaid (CMS) has released a modification to the HCPCS code set. The following procedure codes were reinstated with their original language. There is no longer a termination date of 12/31/2010 for these HCPCS procedure codes. These codes are still valid HCPCS codes.

L3660	L3670	L3675

If you have questions regarding this notice, please contact the HP Enterprise Services Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Thank you for your participation in the Arkansas Medicaid Program.

Eugene I. Gessow, Director