9. Clinic Services (Continued)

(2) Family Planning Clinic Services

Payment based on reasonable negotiated rate.

(3) Maternity Clinic Services

Payment based on reasonable negotiated rate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%

(4) Ambulatory Surgical Center Services

Act 1352 of the 2013 Arkansas General Assembly established reimbursement for Ambulatory Surgery Centers based on 80% of the Medicare Ambulatory Surgery Center procedure code reimbursement rates. Reimbursement is based on the lesser of the provider's actual charges for the service or the Title XIX (Medicaid) maximum. These rates are effective for dates of service beginning July 1, 2013. All rates are published on the agency's website (www.medicaid.state.ar.us). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Ambulatory Surgical Center services. Medicaid will follow Medicare procedure code updates.

In accordance with the Act, Implantable Devices which are not bundled as part of the appropriate procedure code will be reimbursed at a pass-through cost; if the combined documented cost of the appropriate implantable devices is greater than 50% of the appropriate Medicaid maximum procedure code reimbursement rate. If multiple devices are included for one patient, then the total provided devices' cost is calculated and then compared to the appropriate procedure code. The implantable devices' reimbursement provision is also effective for dates of service beginning July 1, 2013. These implantable devices are listed in the provider manual which can be found on the agency's website at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/asc.aspx.

TOC not required

210.200 Definition, Scope and Coverage of Ambulatory Surgical Center (ASC) Services 7-1-14

A. An ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients not requiring hospitalization.
   1. Certain surgical or medical procedures may require prior authorization.
   2. Certain surgeries may require paper billing with attached documentation.

B. Arkansas Medicaid covers as bundled or global services, CMS-approved outpatient surgeries and ASC facility services (such as the following), that are directly related to the surgeries.
   1. Nursing, technician and related services
   2. Use of the facilities where the surgical procedures are performed
   3. Drugs, biologicals for which separate payment is not allowed
   4. Surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the performance of surgical procedures
   5. Diagnostic or therapeutic services or items directly related to the performing of a surgical procedure
   6. Specimen handling when applicable
   7. Administrative, recordkeeping, and housekeeping items and services
   8. Materials for anesthesia
   9. Supervision of the services of an anesthetist by the operating surgeon
   10. CRNA (employee of the ASC)

210.211 Facility Service Exclusions 7-1-14

ASC facility services do not include other items and services that are covered under other Medicaid programs, including laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), collection of specimen by venipuncture when the specimen is sent elsewhere for testing, prosthetic devices, ambulance services; leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home.

210.212 Reserved 7-1-14

210.214 Laboratory, Radiology and Other Diagnostic Procedures 7-1-14

A. Some laboratory, radiology and other diagnostic procedures not directly related to the surgical procedure are eligible for separate reimbursement. See the ASC fee schedule.

B. These diagnostic procedures eligible for separate reimbursement must be billed by the Medicaid-enrolled performing provider.

215.110 Benefit Limits for Laboratory, X-Ray and Machine Tests 7-1-14

Laboratory, X-ray and machine test services in all settings, including ASCs, are subject to a $500.00 expenditure limit per state fiscal year (SFY, July 1 through June 30).

A. Magnetic resonance imaging (MRI) are exempt from the laboratory and X-ray annual benefit limit.

B. Individuals under the age of 21 are not subject to lab and X-ray benefit limits, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

216.121 Procedure Codes for Abortion in the Case of Rape or Incest 7-1-14

See the ASC fee schedule for payable abortion procedure codes in the case of rape or incest.

If the beneficiary requires the Certification Statement for Abortion in an alternative format, such as large print, please contact the Americans with Disabilities Act Coordinator. View or print the certification form DMS-2698. View or print the Americans with Disabilities Act Coordinator contact information.

Field Code Changed

Field Code Changed

216.400 Reserved 7-1-14

216.410 Informed Consent for Hysterectomies 7-1-14

Any Medicaid recipient who is to receive a hysterectomy, regardless of the diagnosis or the age of the patient, must be informed both orally and in writing that the hysterectomy will render the patient permanently incapable of reproduction. The patient or their representative may receive this information from the individual who secures the usual authorization for the hysterectomy procedure.

The patient or their representative, if any, must sign and date the Acknowledgement of Hysterectomy Information (Form DMS-2606) not more than 180 days prior to the hysterectomy procedure being performed. View or print form DMS-2606 and instructions for completion.

Field Code Changed

216.601 Cochlear Implants and External Sound Processors 7-1-14

A. The Arkansas Medicaid Program covers cochlear implantation for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. ASC reimbursement is inclusive of the device and accessories; no separate payment is allowed.

216.602 Reserved 7-1-14

216.603 Organ or Disease Oriented Panels 7-1-14

In order to bill for laboratory tests not included in the ASC payment for covered surgical procedures, an ASC's laboratory must be CLIA-certified and enrolled as a laboratory provider.

216.604 Reserved 7-1-14

216.605 Reserved 7-1-14

216.800 Reserved 7-1-14

216.810 **Reserved** 7-1-14

216.820 **Reserved** 7-1-14

216.830 **Reserved** 7-1-14

216.900 **Reserved** 7-1-14

216.910 **Other Covered Injections and Immunizations with Special Instructions** 7-1-14

The following is a list of injections with special instructions for coverage and billing. The table of payable procedure codes is designed with eight columns of information.

A. The **first** column of the list contains the CPT or HCPCS procedure codes.

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

C. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years(y) or months (m).

D. The **fourth** column indicates specific ICD primary diagnosis restrictions.

E. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used.

F. The **sixth** column indicates whether a procedure is subject to medical review before payment.

G. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided.

H. The **eighth** column indicates if a procedure code requires a prior approval letter from the Arkansas Medicaid Medical Director for Clinical Affairs for the Division of Medical Services. **View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services**.

Field Code Changed

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7321	No	No	No	No	No	Yes	No
J7323	No	No	No	No	No	Yes	No
J7324	No	No	No	No	No	Yes	No
J7325	No	No	No	No	No	Yes	No

NOTE: Prior authorization is required for coverage of the Viscosupplementation injection in the ASC for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for these procedure codes. A written request must be submitted to the Division of Medical Services Utilization Review Section. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, ASC Arkansas Medicaid Provider number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments, results and site of injection.

221.000 Prior Authorization Information 7-1-14

A. Clinical criteria for prior authorization (PA) must support the medical necessity for the procedure and/or must be appropriate for the particular condition or disorder.

B. Arkansas Foundation for Medical Care, Inc. (AFMC), Arkansas Medicaid's Quality Improvement Organization (QIO), reviews—and approves or denies—requests for outpatient surgery PA.

1. Request PA for outpatient surgeries by telephone. **View or print AFMC contact information.** AFMC records all calls.
2. The performing physician must initiate the PA request; however, the call to AFMC may be made by a member of the physician's medical staff who is familiar with medical records and conversant in medical terminology; for instance, an RN or a physician's assistant.
3. The performing physician must have on file in the patient's medical records the documentation of medical necessity that supports the request for PA.

C. Prior authorization does not guarantee payment: providers must comply with all Medicaid regulations related to the medical service.

1. The beneficiary must be eligible on the date of service.
2. The provider's Arkansas Medicaid enrollment must be effective for the date of service.
3. Most ASC outpatient surgeries require a referral from the beneficiary's primary care physician (PCP).
4. The PA number must be on the claim (i.e. the procedure code billed must be the procedure code on the PA file).
5. Claims for some procedures must be submitted on paper and accompanied by operative reports, consent forms or other documentation and are not accepted electronically or without the required attachments.

Field Code Changed

221.100 Prior Authorization Request and Notification Procedures 7-1-14

The procedures in this section apply to all requests for PA of outpatient surgeries.

A. The attending physician or the physician's office nurse (or a licensed physician assistant) must furnish the following information by telephone to AFMC.

1. The beneficiary's name and address
2. The beneficiary's Medicaid identification number
3. The physician's name and state license number
4. The physician's provider identification number
5. The facility's name
6. The date of the procedure

B. AFMC approves or denies the request by telephone and follows up with written confirmation of the determination.

1. In approved cases, AFMC assigns a prior authorization control number to the case.
2. When AFMC denies a PA request, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of this manual).

C. AFMC forwards individual written confirmation to the surgeon.

D. It is important to note that the surgeon is ultimately responsible for ensuring that the facility (as well as any other affected provider, such as the anesthetist) has a copy of the authorization to file and to use for billing purposes.

221.110 Reserved 7-1-14

221.120 When Beneficiary Medicaid Eligibility is Determined Retroactively 7-1-14

A. When an individual becomes Medicaid-eligible retroactively *and* the provider agrees to bill Medicaid, the eligibility authorization date is the date on which an individual is officially determined or declared eligible for a program such as Medicaid, ARKids First-A or ARKids First-B and the eligibility file is activated in Medicaid's computers.

B. When someone becomes eligible retroactively, filing deadlines and other limited periods are calculated from the eligibility authorization date instead of from the date(s) of service.

The eligibility authorization date is seldom the same date as the eligibility segment's effective date.

221.130 Reserved 7-1-14

222.000 Outpatient Surgeries That Require Prior Authorization 7-1-14

The following procedure codes require prior authorization.

Outpatient Surgeries That Require Prior Authorization	
59840	59841

A. Refer to Section 216.110, "Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term," for the prior authorization process.

B. Refer to Section 216.120, "Abortion When the Pregnancy Is a Result of Rape or Incest," for the prior authorization process.

C. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report

attached. View a sample CMS-1450 (UB-04) claim form. View or print form DMS-2698.

Field Code Changed

Field Code Changed

223.000 Prior Authorization of Viscosupplementation 7-1-14

A. A written request must be submitted to the Division of Medical Services Utilization Review Section. View or print the Division of Medical Services Utilization Review Section address.

Field Code Changed

B. Prior authorization is required for coverage of the Viscosupplementation in the ASC for procedure codes **J7321, J7323, J7324 and J7325**. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. The PA request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, ASC Arkansas Medicaid Provider number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection.

230.100 Reimbursement 7-1-14

Covered dental surgical procedures in the ASC are assigned to one of four groups for reimbursement purposes. Billing instructions are in Section 242.110.

A. Medicaid has established a maximum allowable fee for each dental surgical group.

1. Reimbursement is the lesser of the billed charge or the maximum allowable fee for the applicable dental surgical group.
2. The maximum allowable fees are global fees that include all of the covered ASC facility services listed in Section 210.200.

B. When multiple surgical procedures are performed on the same date of service, surgical procedures subject to the multiple procedure (MP) discount will be reimbursed in the following manner:

1. The surgical code with the highest reimbursement will be paid at 100%; the 2nd code at 50% if subject to the MP discount and the 3rd code at 50% if subject to the MP discount.
2. Procedures not subject to the MP discount and allowed separate reimbursement will be reimbursed according to the ASC fee schedule.

230.110 ASC Procedures 7-1-14

Covered procedures for ASCs can be found on the ASC fee schedule on the Arkansas Medicaid website.

232.000 Specimen Collection and Handling 7-1-14

There is no separate reimbursement for the collection and handling of specimens.

233.000 Reserved 7-1-14

234.000 Reserved 7-1-14

241.000 Introduction to Billing 7-1-14

Ambulatory Surgical Center providers use the Uniform Billing form CMS-1450 (UB-04) to bill the Arkansas Medicaid Program on paper. Each claim may contain charges for only one beneficiary.

A Medicaid claim may contain only one billing provider's charges for services furnished to only one Medicaid beneficiary.

Section III of this manual contains information regarding Provider Electronic Solutions (PES) and other available options for electronic claims submission.

All details billed (electronically or on paper) by an ASC provider require the modifier SG, "Ambulatory Surgical Center (ASC) facility service." See Section 242.100 for Dental billing.

National Correct Coding Initiative (NCCI) editing applies to all claim submissions.

Arkansas Medicaid accepts claims that include national modifiers.

242.110 ASC Dental Billing 7-1-14

Outpatient dental surgical procedures performed in an ASC are billed to Medicaid with revenue codes rather than with HCPCS or CPT procedure codes. Bill Medicaid with the revenue code that is in the same outpatient surgical group as the surgery performed. Modifier SG should **not** be billed with Dental surgery revenue codes below.

Revenue Code	Description
0361	Group I, Outpatient Dental Surgery
0360	Group II, Outpatient Dental Surgery
0369	Group III, Outpatient Dental Surgery
0509	Group IV, Outpatient Dental Surgery

242.120 Reserved 7-1-14

242.130 Reserved 7-1-14

242.140 Reserved 7-1-14

242.141 Reserved 7-1-14

242.145 Reserved 7-1-14

242.150 Verteporfin (Visudyne) 7-1-14

A. Medicaid reimburses ASCs for Verteporfin (Visudyne), HCPCS procedure code **J3396,** when it is furnished to Medicaid-eligible beneficiaries.

1. Reimbursement for Verteporfin is not included in the reimbursement for the related surgical procedure,

2. Providers may bill Medicaid separate charges for Verteporfin and the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD-9-CM diagnosis codes.

115.02 115.12 115.92 360.21 362.50 362.52

C. Use anatomical modifiers to identify the eye(s) being treated.

D. **J3396** may be billed electronically or on a paper claim.

E. NDC billing protocol must be followed for this drug. See Section 242.400.

242.160 Reserved 7-1-14

242.161 Reserved 7-1-14

242.200 Reserved 7-1-14

242.400 Drug Procedure Codes and National Drug Codes (NDCs) 7-1-14

Effective for claims with dates of service on or after July 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Health Care Financing Administration Common Procedure Code System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each State a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first 5 digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first 5 digits of the NDC) to the list of covered labelers which is maintained on the Arkansas Medicaid website.

A complete listing of **"Covered Labelers"** is located on the Arkansas Medicaid web page at **www.medicaid.state.ar.us**, click on Provider Services, select Prescription Drug information and then select Covered Labelers. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*. In order for a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three segments or codes: a 5-digit labeler code, a 4-digit product code and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero in one of the three segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 1 displays the labeler code as five digits with leading zeros; the product code as four digits with leading zeros; the package code as two digits without leading zeros, using the "5-4-2" format.

Diagram 1

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 2 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 2

10-digit FDA NDC on PACKAGE	**Required 11-digit NDC (5-4-2) Billing Format**
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPC/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one labeler to another, from one package size to another, and from one time period to another.

Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

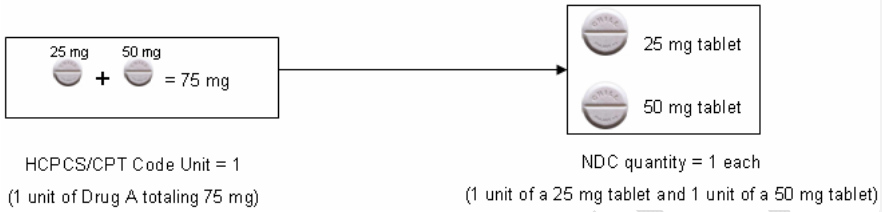
C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of

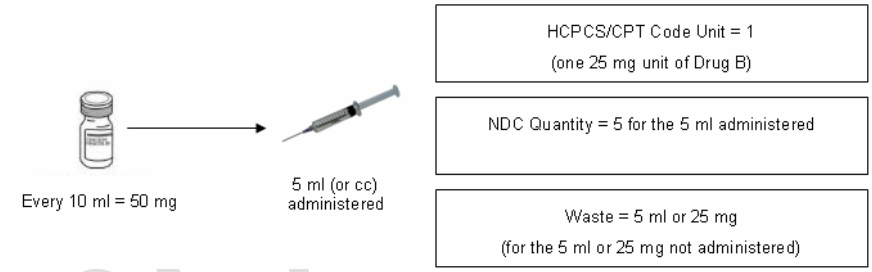
75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 3



Example 2: the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted.

Diagram 4



D. Electronic Claims Filing 837I (Outpatient)

Electronic claims can be filed with a maximum of 5 NDCs per detail.

Procedure codes that do not require paper billing may be billed electronically. Any procedure codes that have required modifiers in the past will continue to require modifiers.

Arkansas Medicaid will require providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

When billing multiple NDCs, the HCPCS/CPT should reflect the total charges and units of all administered NDCs. The NDC fields should reflect the price and units of each specific NDC, up to a maximum of five NDCs per detail.

For 837I outpatient claims, from the Service tab, in the RX Indicator field, select "Y" to open the RX tab. On the RX tab, enter the NDC, Unit of Measure, Quantity and Price for each NDC.

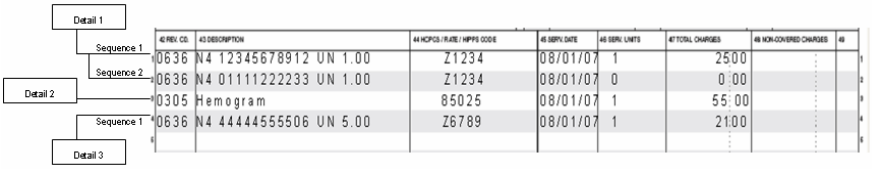
If billing electronic claims using vendor software, check with your vendor to ensure your software will be able to capture the criteria necessary to submit these claims. Vendor companion guides are located on the Arkansas Medicaid web page at **www.medicaid.state.ar.us**. Click on Provider, select HIPAA, select Documents for vendors and then select Companion guides.

E. Paper Claims Filing CMS-1450 (UB-04)

Arkansas Medicaid will require providers billing drug HCPCS/CPT codes, including covered unlisted drug procedure codes, to use the required NDC format.

For institutional outpatient claims on the CMS-1450 (UB-04), use the locator field 43 (Description) to list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 - International Unit; GR - Gram; ML - Milliliter; UN - Unit), and number of units of the actual NDC administered, spaced and arranged exactly as in Diagram 5. Each NDC, when billed under the same procedure code on the same date of service, is defined as a "sequence." When billing a single HCPCS/CPT code with multiple NDCs as detail sequences, the first sequence should reflect the total charges in the detail locator field 47 and total HCPCS/CPT code units in locator field 46. Each subsequent sequence number should show zeros in locator fields 46 and 47. See Detail 1, sequence 2 in Diagram 5. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 5, first detail, sequences 1 and 2. Detail 2 is a Procedure Code that does not require an NDC. Detail 3, sequence 1 gives an example where only one NDC is associated with the HCPCS/CPT code.

Diagram 5



F. Procedure Code/NDC Detail Attachment Form-DMS-664

For drug HCPCS/CPT codes requiring paper billing (i.e. for manual review), complete every field of the DMS-664 "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing. See Diagram 6 for an example of the completed form. **View or print form DMS-664 and instructions for completion**.

Field Code Changed

Diagram 6

Detail #	Sequence #	NDC	Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	1 2 3 4 5 6 7 8 9 1 2	Z1234	ABC drug/25 MG/Oral	0
1	2	0 1 1 1 1 2 2 2 2 3 3	Z1234	XYZ drug/50 MG/Oral	0
3	1	4 4 4 4 4 5 5 5 5 0 6	Z6789	PRQ drug/5 ML/IV	5 ML

G. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

H. Remittance Advices

Only the first sequence in a detail will be displayed on the remittance advice reflecting either the total amount paid or the denial EOB(s) for the detail.

I. Drug Efficacy Study Implementation (DESI) Drugs

The Federal Drug Administration (FDA) reviews the effectiveness of drugs approved between 1938 and 1962 through a program named the Drug Efficacy Study Implementation (DESI) program. Drugs that were approved by the FDA before 1962 were permitted to remain on the market while evidence of their effectiveness was reviewed. If the DESI review indicates a lack of substantial evidence of a drug's effectiveness, the FDA will publish its proposal to withdraw approval of the drug for marketing. In accordance with Section 1903(i)(5) of the Social Security Act, federal funds participation (FFP) is not available for Less than Effective (LTE) drugs or the Identical, Related or Similar (IRS) drugs identified by the FDA and published quarterly by the Centers for Medicare and Medicaid Services.

This means that any HCPCS/CPT code will not be payable when linked to any NDC with a DESI indicator. If it is determined that all NDCs linked to a specific HCPCS/CPT are DESI, this is an instance where the procedure code will no longer be payable.

A list of "DESI" drugs with the effective and end dates will be on the Arkansas Medicaid website. From the main page, click Provider Services, select Prescription Drug Information and then select DESI NDCs (non-payable) associated with HCPCS/CPT codes.

J. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer. At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

242.410 Reserved **7-1-14**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-682-2480
TDD/TTY: 501-682-6789

TO: **Arkansas Medicaid Health Care Providers – Ambulatory Surgical Center**

DATE: **July 1, 2014**

SUBJECT: **Provider Manual Update Transmittal ASC-1-14**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
210.200	11-1-07	210.200	7-1-14
210.211	11-1-07	210.211	7-1-14
210.212	11-1-07	210.212	7-1-14
210.214	11-1-07	210.214	7-1-14
215.110	2-1-05	215.110	7-1-14
216.121	8-15-09	216.121	7-1-14
216.400	10-13-03	216.400	7-1-14
216.410	10-13-03	216.410	7-1-14
216.601	11-1-07	216.601	7-1-14
216.602	11-1-07	216.602	7-1-14
216.603	11-1-07	216.603	7-1-14
216.604	5-1-08	216.604	7-1-14
216.605	8-15-09	216.605	7-1-14
216.800	11-1-07	216.800	7-1-14
216.810	11-1-07	216.810	7-1-14
216.820	11-1-07	216.820	7-1-14
216.830	11-1-07	216.830	7-1-14
216.900	6-30-11	216.900	7-1-14
216.910	11-1-08	216.910	7-1-14
221.000	11-1-07	221.000	7-1-14
221.100	5-1-07	221.100	7-1-14
221.110	5-1-07	221.110	7-1-14
221.120	5-1-07	221.120	7-1-14
221.130	5-1-07	221.130	7-1-14
222.000	8-15-09	222.000	7-1-14
223.000	8-15-09	223.000	7-1-14
230.100	11-1-08	230.100	7-1-14
230.110	8-15-09	230.110	7-1-14

232.000	5-1-07	232.000	7-1-14
233.000	5-1-07	233.000	7-1-14
234.000	5-1-07	234.000	7-1-14
241.000	11-1-08	241.000	7-1-14
242.110	11-1-07	242.110	7-1-14
242.120	11-1-07	242.120	7-1-14
242.130	5-1-07	242.130	7-1-14
242.140	11-1-07	242.140	7-1-14
242.141	8-15-09	242.141	7-1-14
242.145	6-1-06	242.145	7-1-14
242.150	6-30-11	242.150	7-1-14
242.160	11-1-07	242.160	7-1-14
242.161	8-15-09	242.161	7-1-14
242.200	7-1-07	242.200	7-1-14
242.400	—	242.400	7-1-14
242.410	7-1-07	242.410	7-1-14

Explanation of Updates

Section 210.200 is updated to clarify coverage of ASC services for drugs and biologicals.

Section 210.211 is updated to clarify facility service exclusions.

Sections 210.212, 216.400, 216.602, 216.604, 216.605, 216.800, 216.810, 216.820, 216.830, 216.900, 221.110, 221.130, 233.000, 234.000, 242.120, 242.130, 242.140, 242.141, 242.145, 242.160, 242.161, 242.200 and 242.410 are set to Reserved and their content is deleted.

Section 210.214 is updated to clarify the reimbursement policy for laboratory, radiology and other diagnostic procedures.

Section 215.110 is updated to clarify the procedures exempt from the laboratory and X-ray annual benefit limit.

Section 216.121 is updated to refer providers to the ASC fee schedule for payable abortion procedure codes in the case of rape or incest.

Section 216.410 is renamed to indicate it contains information regarding informed consent for hysterectomies.

Section 216.601 is updated to clarify the reimbursement policy for cochlear implants and external sound processors.

Section 216.603 is updated with current policy for billing laboratory tests that are not included in the ASC payment for covered surgical procedures.

Section 216.910 is updated with the current list of injections with special instructions for coverage and billing.

Section 221.000 is updated with current policy for requesting prior authorization.

Section 221.100 is updated with current prior authorization request and notification procedures.

Section 221.120 is updated with current policy for retroactive Medicaid eligibility.

Section 222.000 is updated to reflect the current procedure codes for outpatient surgeries that require prior authorization.

Section 223.000 is updated with current policy for requesting prior authorization for Viscosupplementation.

Section 230.100 is updated with current reimbursement policy for dental procedure codes.

Section 230.110 is renamed and updated to direct providers to the ASC fee schedule for ASC procedures.

Section 232.000 is updated to indicate that specimen collection and handling does not have separate reimbursement.

Section 241.000 is updated to clarify billing policy.

Section 242.110 is updated to clarify policy for billing outpatient dental surgical procedures performed in an ASC.

Section 242.150 is updated to clarify reimbursement for Verteporfin (Visudyne).

Section 242.400 is updated to include information on drug procedure codes and National Drug Codes (NDCs).

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas 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 the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.

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Andrew Allison, PhD
Director