

Division of Medical Services

Program Development & Quality Assurance

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TO:

Arkansas Medicaid Health Care Providers - Ambulatory Surgical Center

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal ASC-2-15

REMOVE		INSERT	
Section	Date	Section	Date
242.400	7-1-14	242.400	10-1-15
242.410	7-1-14	242.410	10-1-15

Explanation of Updates

Section 242.400 is updated to include National Drug Code (NDC) information.

Section 242.410 is updated to include current drug vial policy.

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.

Dawn Stehle Director

TOC is required

242.400 Drug Procedure Codes and National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellantx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER CODE	LABELER NAME	DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	400000000000000000000000000000000000000
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTE	MS 10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT CODE	PACKAGE CODE
CODE	(4 digits)	(2 digits)
(5 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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

Required 11-digit NDC (5-4-2) Billing Format
12345678901
01111222233
01111 0 45671

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

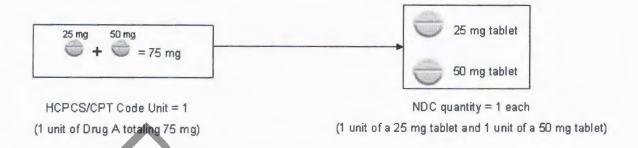
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

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

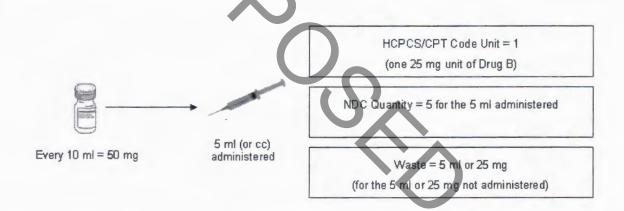
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If 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. See Diagram 5.

Diagram 5



D. Electronic Claims Filing 837I (Outpatient)

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.

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 6. 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 6. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

	C	40 MBV CS	AS DESIGNATION	44 MOPOS (MUSE: HIPPS CODE	49.380F9:04F6	86-530% S,METS	er forel, constable	46 HOLDSHEPED CHARGES	-
	Sequence 1	0636	N4 12345678912 UN 1.00	Z1234	08/01/07		2500		10000
	Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00		-
Detail 2		0305	Hemogram	85025	08/01/03	1	55:00		-
	Sequence 1	0636	N4 44444555506 UN 5.00	I6789	08/01/07	1	2100	N. A.	

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 7 for an example of the completed form. <u>View or print form DMS-664 and instructions for completion</u>.

Diagram 7

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	11	4	4	4	4	4	5	5	5	5	0	6	26789	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.

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 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

Mark Up

TOC is required

242.400

Drug Procedure Codes and National Drug Codes (NDCs)

7-1-14<u>10-1-</u> 15

Effective for claims with dates of service on or after <u>July January</u> 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. <u>This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.</u>

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Health<u>c</u>-Care Financing Administration Common Procedure Codinge 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 at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. Arkansas Medicaid web page at www.medicaid.state.ar.us, click on Provider Services, select Prescription Drug information and then select Covered Labelers. See Diagram 1 for an example of this screen. 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.

Diagram 1

(LABELET)	LABELER MAME	DATE T	DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	1,000
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 4-2 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 42

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 2-3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 23

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	01111 0 45671

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

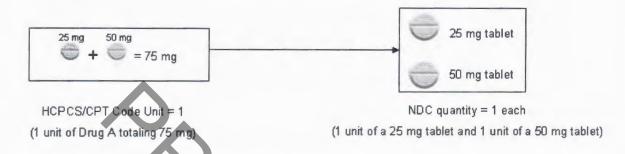
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

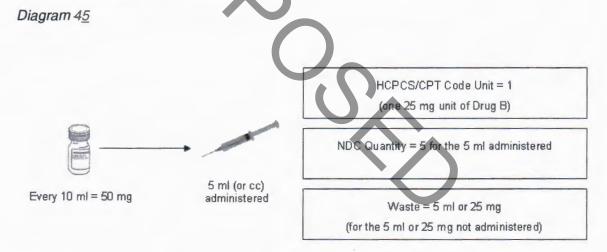
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 34



Example 2: If 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. See Diagram 5.



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 56. 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 56. The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 56, 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 56

	Sequence 1	-	A E DONCHIPTOR	44 NCPCS / NURE: 1077% 0306	AT BOOK SHIPS AND AND EASTER	47 TONE; CHANGGA	AND RESTAURCH CHARACTERS AND
		0636	N4 12345678912 UN 1 00	Z1234	08/01/07 1	2500	
	Sequence 2	0636	N4 01111222233 UN 1 00	Z1234	08/01/87 0	0.00	
Detail 2		0305	Hemegram	85025	08/21/07	55:00	
	Sequence 1	0636	N4 44444555506 UN 5.00	Z6789	08/81/07 1	21:00	, ,

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 6-7 for an example of the completed form. View or print form DMS-664 and instructions for completion.

Diagram 6-7

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.

JI. 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 ReservedBilling of Multi-Use and Single-Use Vials

7-1-14<u>10-1-</u>

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage

given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

- Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
- Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
- Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
- 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - ARKids First-B

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal ARKIDS-3-15

REMOVE

INSERT

Section

Section

Date

262.431

10-1-15

Explanation of Updates

Section 262.431 is added to include current drug vial policy.

Date

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.

Dawn Stehle

Director

TOC is required

262.431 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicard will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

Mark up

TOC is required

262.431 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
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 - Single-Use Wals: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
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 - 3. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: For drug HCPCS/CRT 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.



Division of Medical ServicesProgram Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437

501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Certified Nurse-Midwife

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal CNM-1-15

REMOVE		INSERT	
Section	Date	Section	Date
		272.531	10-1-15
		272.532	10-1-15

Explanation of Updates

Section 272.531 is added to include National Drug Code (NDC) information.

Section 272.532 is added to include current drug vial policy.

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.

Stehle Frat

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle

Director

TOC required

272.531 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	VEREITIVE CLAYE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

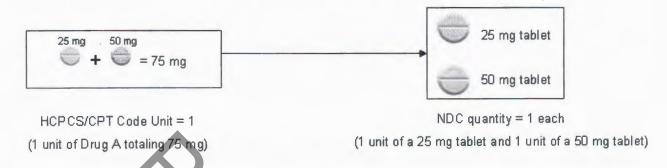
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

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

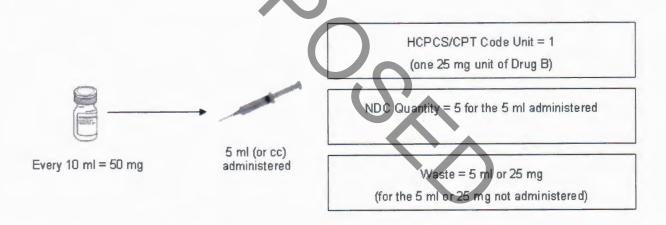
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If 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. See Diagram 5.





A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, Sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Certified Nurse-Midwife

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 272.532 for additional information regarding drug code billing.

272.532 Injections, Therapeutic and/or Diagnostic Agents

10-1-15

- A. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.

TOC required

272.531 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER HAME	EFFECTIVE	TERMINATION: DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	-
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (54-2) Billing Format
12345-6789-1	12345678901
1111-2222-33	01111282233
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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

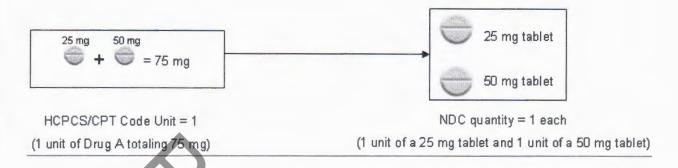
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

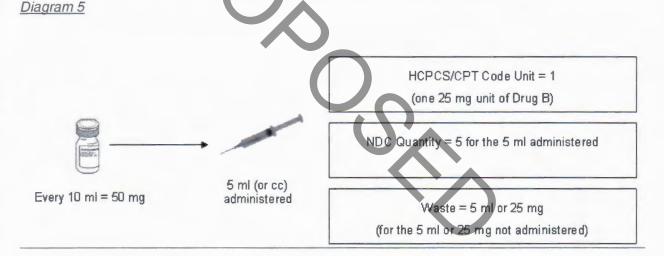
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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. See Diagram 5.



- A. Electronic Claims Filing 837P (Professional) and 837I (Outpatient)
 - 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 requires providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.
- B. Paper Claims Filing CMS-1500
- Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.
 - See Diagram 6 for CMS-1500.
 - For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 International Unit; GR Gram; ML Milliliter; UN Unit) and the

number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, Sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Certified Nurse-Midwife Section II

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 272.532 for additional information regarding drug code billing.

272.532 Injections, Therapeutic and/or Diagnostic Agents

10-1-15

- A. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.531 for additional information regarding National Drug Code (NDC) billing.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Child Health Services/Early

and Periodic Screening, Diagnosis, and Treatment

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal EPSDT-2-15

REMOVE Section

Date

INSERT

Section 242,141

Date 10-1-15

Explanation of Updates

Section 242.141 is added to include current drug vial policy.

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.

Days Stehle Pair

Director

TOC required

242.141 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
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 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

TOC required

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Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Hospital/Critical Access

Hospital (CAH)/End Stage Renal Disease (ESRD)

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal HOSPITAL-3-15

REMOVE		INSERT	
Section	Date	Section	Date
272.102	5-17-10	272.102	10-1-15
272.510	1-15-15	272.510	10-1-15

Explanation of Updates

Section 272.102 is updated to include current National Drug Code (NDC) information.

Section 272.510 is updated to include current drug vial policy.

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.

Dawn Stehle

Director

TOC not required

272.102 Drug Procedure Codes and National Drug Codes (NDC)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. 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		PACKAGE CODE
(5 digits)	(4 digits)	(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

	Required 11-digit NDC
10-digit FDA NDC on PACKAGE	(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 HCPCS/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.

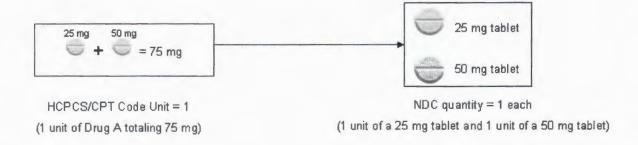
Exception: There is no requirement for an NDC when billing for vaccines.

C. Claims Filing

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

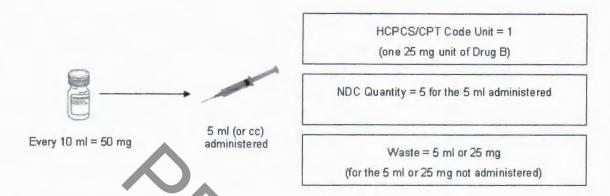
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example, whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 3.

Diagram 3



Example 2: If 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 8371 (Outpatient)

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.

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 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

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	Sequence 1	0636	N4 12345678912 UN 1.00	Z1234	08/01/07		2500		-
	Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/01	0	0.00		NATURAL CONTRACTOR
Detail 2		0305	Hemogram	85025	08/01/03	1	55:00	disconnection .	acres and
	Sequence 1	0636	N4 44444555506 UN 5.00	Z6789	08/01/07	4	21.00	A A	MUNION.

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.

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.

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.

See Section 272.510 for additional information regarding National Drug Code (NDC) billing.

272.510 Injections, Radiopharmaceuticals and Therapeutic Agents

10-1-15

Intravenous administration of therapeutic agents is payable only if provided in an outpatient setting. Therapeutic injections should only be provided by facilities that have the capacity to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Reimbursement for supplies is included in the administration fee. Use procedure code **96365** for IV infusion therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code **0760** (for observation), up to 8 hours maximum per day. For monoclonal antibody intravenous infusion use procedure code **76403**.

Multiple units may be billed for drug procedure codes, if appropriate. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as take home drugs.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
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 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (ODC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.102 for additional information regarding National Drug Code (NDC) billing.

See Section 272.450 for special billing instructions and coverage of Radiopharmaceuticals.

For coverage information regarding any drug not listed, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

The following is a list of injections with special instructions for coverage and billing:

Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- 1. The first column of the list contains the CPT or HCPCS procedure codes.
- 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 <u>third</u> 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).
- 4. The **fourth** column indicates specific ICD-9-CM primary diagnosis restrictions.
- The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.

- The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 241.000 for prior authorization.)
- 8. The <u>eighth</u> 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. (See Section 272.103 for Prior Approval.) <u>View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services</u>.

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0- 175.9	No	No	No	No
A9542*	No	No	No	No	No	No	Yes
A9543*	No	No	No	No	No	No	Yes
A9544*	No	No	No	No	No	No	Yes
A9545*	No	No	No	No	No	No	Yes
		nent failures that xamination mu No			xperiences	and the pa	tient's history Yes
NOTE: Prio	r Approval is	required before	e services ass	sociated with	the use of th	e procedur	e code must be
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A9555* NOTE: To sub dia A9557 A9559* NOTE: Atta A9563 A9575	olided. To obmitted along diagnostic. No obtain Prior omitted along gnostic and No No No ach the mar	No Approval, a cog with a report attach a copy No No No No No No No No	No Doy of the part on what other of the manufacture with the control of the manufacture with the control of the manufacture with the control of the control	No tient's history er profusion s acturer's invo No No No No	No No No No No	No Rat exam m been tried laim. No No	No No No No No No No
A9555* NOTE: To sub dia A9557 A9559* NOTE: Atta A9563 A9575 A9580*	nided. To obmitted along diagnostic. No obtain Prior omitted along gnostic and No No No ach the mar No No No	No Approval, a cong with a report of No Approval, a cong with a report attach a copy No No No No No No No 2y& up	No Doy of the part on what other of the manufacture with the control of the manufacture with the control of the	No tient's history er profusion s acturer's invo No No No No No No	No No No No No	No No No No	No No No No No No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

No

No

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
A9582*	No	No	No	No	No	No	No
NOTE:	Attach the mar	nufacturer's inv	oice to the cl	aim.			
A9585*	No	2y & up	No	No	No	No	No
A9586*	No	18y & up	331.0- 332.1	No	No	No	No
NOTE:	Attach the mar	nufacturer's inv	oice to the cl	aim.			
A9604*	No	21y & up	No	003	No	No	No
NOTE:	Attach the mar	nufacturer's inv	oice to the cl	aim.			
C1841*	No	No	362.74	No	No	No	No
NOTE: A	Attach the manu	facturer's invoid	ce to the claim	٦.			
C8931	No	No	No	No	No	No	No
C8932	No	No	No	No	No	No	No
C8934	No	No	No	No	No	No	No
C8935	No	No	No	No	No	No	No
C8936	No	No	No	No	No ·	No	No
C9132	No	18y & up	286.7	No	Yes	No	No
	Kcentra is indi by Vitamin K a Kcentra is not major bleeding and physical ed documented. A the dose of wa	ntagonist (VKZ indicated for u Documentat xam. All treatr A hemoglobin	Z, e.g. warfari irgent reversation of the ma ments needed	in) therapy in al of VKA ant jor bleed sho d for the majo	adult patier icoagulation ould be included by the price of the price o	nts with may rin patients ided in a co or to Kcent i	jor bleeding. s without acute emplete histor ra should be
C9133	No	18y & up	No	No	No	No	No
C9248	No	No	No	No	No	No	No
C9254	No	18y & up	No	No	No	No	No
C9256	No	No	No	No	No	No	No
			Yes	No	Yes	No	Yes

included with Prior Approval Letter request must include Fluoroscein angiogram or OCT,

No

No

patient screen for conditions that would contraindicate the use of Avastin, and

940.00-949.50

documentation of patient consent.

No

No

C9363

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
C9441	No	18y & up	280.0- 280.9	No	No	No	No
			AND				
			285.1				
			OR				
			585.1- 585.9				

NOTE: Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

C9733	No	No	No	No	No	No	No
C9734	No	No	No	No	No	No	No
J0120	No	No	No	003	No	No	No
J0129*	No	No	714.0- 714.2	No	No	No	Yes

NOTE: Patient must have had inadequate response to one or more disease-modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis, etc.

J0130	No	No	No	003	No	No	No
J0132	No	No	965.4	No	No	No	No
J0133	No	No	053.0- 054.9	No	No	No	No
J0150	No	No	No	No	No	No	No
NOTE:	Maximum u	nits allowed a	are 4 per day.				
J0151	No	No	No	No	No	No	No
J0171	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

capability.

No

No

273.4

No

No

No

No

J0256

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0178*	No	18y & up	362.52	No	Yes	No	Yes
ca hy de Pa in th ris th le co ar	tre. Contrain persensitivity etachments. attents should traocular presented by factors of see Medical Direction type, locally unusual respectively.	only be administrated in oculus. Intravitreal in Patients should be monitored source seen with a cevents followeroke, myocarrector for Clinication and size ual dosage, sin actions. All of or Approval le	lar or periocular or periocular or periocular of be instructed for 60 minuted in Eylea injection use of the dial infarction cal Affairs as and presence, lot numbe this must be	lar infections we been asso- ed to report a es after injections. There is class of dra or vascular well as OCT e of subretinar of the vial, of	, active intractiated with a ciated with a ny sympton tion due to a is a potentiugs. Patier events. Sulpor fluorescell fluid. The late and time	aocular inflatendophthalins as soon acute increadal risk of antits should bornit screen angiograph	ammation and mitis and retina as possible. ases in terial e screened for ing history to am to evaluate acord must stration and
J0180*	No	No	272.7	No	No	No	Yes
J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	No	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	271.0	No	No	No	Yes
	aluation by a	physician with	h a specialty	in clinical ger	netics docu	menting pro	gress required
J0221*	No	No	271.0	No	Yes	No	Yes
Po no Th Pr dis re	ompe disease t infantile, Poste beneficiary ogram. The scussion of the actions according to the control of the	neficiaries who e. The history ompe disease or, physician an history and phane risks of anal rding to the Blana a facility equi	and physical must be subr d infusion ce ysical should phylaxis, sev ack Box Warr	by a genetic mitted with the nter should be document co ere allergic re ning from the	st showing e request for e enrolled in ompliance ve eactions and FDA. This	a diagnosis or the prior a on the Lumiz with this pro- d immune-n drug should	of late onset, approval letter. yme ACE gram including nediated

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol). See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0257	No	18v & up	273.4	No	No	No	No

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable. clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to alpha 1 proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No
J0280	No	No	No	003	No	No	No
J0282	No	No	No	003	No	No	No
J0285	No	No	No	003	No	No	No
J0287	No	No	No	003	No	No	No
J0288	No	No	No	003	No	No	No
J0289	No	No	No	003	No	No	No
J0290	No	No	No	003	No	No	No
J0295	No	No	No	003	No	No	No
J0300	No	No	No	003	No	No	No
J0330	No	No	No	003	No	No	No
J0348	No	No	Yes	003	No	No	No

NOTE: Procedure code J0348 is valid for any condition below, along with ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5th digits), or 112.9 (1) End-stage Renal Disease (ICD-9-CM codes 584 – 586) or (2) AIDS or cancer (List 003) or (3) Post transplant status (i.e., ICD-9-CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date.

J0350	No	No	No	003	No	No	No
J0360	No	No	No	003	No	No	No
J0364	No	No	No	No	No	No	No
J0380	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

No

No

See Section 241.000 for prior authorization procedures.

J0592

No

No

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0390	No	No	No	003	No	No	No
J0400	No	No	No	No	No	No	No
J0401	No	13y & up	295.00- 295.95	No	No	No	No
J0456	No	No	No	003	No	No	No
J0461	No	Nø	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	V42.0	No	No	No	No
J0485	No	18y & up	V42.0	No	No	No	No
J0490*	No	18y & up	695.4	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.

J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is re	eviewed for med	dical neces	sity based on	ICD-9-CM d	iagnosis cod	ie.
J0586	No	No	No	No	Yes	No	No
NOTE:	This proced code billed.	ure code is revi	ewed for m	edical neces	sity based on	an ICD-9-C	M diagnosis
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD-9-C	M diagnosis cod	de which su	upports medic	al necessity	is required.	

003

No

No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0595	No	No	No	003	No	No	No
J0597*	No	13y & up	277.6	No	Yes	No	No
	his code will l ubmitted.	be reviewed fo	r medical ned	cessity based	on the clin	ical docum	entation
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
	No	No	No	003	No	No	No
J0630	NO	110					INO
J0636	No	No	584-586	No	No	No	No

NOTE: Procedure code J0637 is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage. After 30 days of use, an updated medical exam and history must be submitted.

J0638	No	4y &up	277.31	No	No	No	No
J0640	No	No	No	003	No	No	No
J0641*	No	No	170.0- 170.9	No	Yes	No	Yes

NOTE: Approved Only:

1. After high methotrexate therapy in osteosarcoma

OR

To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.

J0670	No	No	No	003	No	No	No
J0690	No	No	No	003	No	No	No
J0692	No	No	No	003	No	No	No
J0694	No	No	No	003	No	No	No
J0696	No	No	No	003	No	No	No
J0697	No	No	No	003	No	No	No
J0698	No	No	No	003	No	No	No
J0702	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code from range 640 – 648.93 for complications of pregnancy or List 003 for all ages.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0706	No	No	No	003	No	No	No
J0710	No	No	No	003	No	No	No
J0712	No	18y & up	No	No	No	No	No
J0713	No	No	No	003	No	No	No
J0715	No	No	No	003	No	No	No
J0716	No	No	989.5	No	No	No	No
J0717*	No	18y & up	555.0- 555.9	No	Yes	No	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (Cimzia) 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 corticosteroids or 6mercaptopurine/azathioprine.

For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed Enbrel and Humira.

J0720	No	No	No	003	No	No	No	

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0725	No	No	No	003	No	No	No
J0735	No	No	No	003	No	No	No
J0740	No	No	No	003	No	No	No
J0743	No	No	No	003	No	No	No
J0744	No	No	No	003	No	No	No
J0745	No	No	No	003	No	No	No
J0760	No	No	No	003	No	No	No
J0770	No	No	No	003	No	No	No
J0780	No	No	No	003	No	No	No
J0795	No	No	No	003	No	No	No
J0800	No	No	No	003	No	No	No
J0833	No	No	No	No	No	No	No
J0834	No	No	No	No	No	No	No
J0850	No	No	No	003	No	No	No
J0878	No	No	No	No	No	No	No

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881	No	No	Yes; see	No	No	No	No

NOTE: For all diagnoses, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

In addition to the primary diagnosis, an ICD-9-CM diagnosis code from each column below must be billed on the claim.

Column	Column II					
	Code	Description				
285.9 Secondary Anemia	V58.11	Encounter for antineoplastic chemotherapy				
'()	V67.2	Following chemotherapy				
	E933.1	Antineoplastic and immunosuppressive drugs				

Use ICD-9-CM code **285.29** (primary) with **070.54**, **238.72-238.75** or **714.0-714.4** (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

Column I	Column II					
	Code	Description				
285.29 Anemia of other chronic disease	070.54	Chronic Hepatitis C without mention of coma				
	238.72- 238.75	Myelodysplastic				
	714.0- 714.4	Rheumatoid Arthritis				

J0882	No	No	584-586	No	No	No	No
J0885							
NOTE:		ure code J08 ICD-9-CM 2	81 in this section 85.21.	n for speci	fic criteria. W	hen the ben	eficiary is not on
J0886	No	No	584-586	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0894*	No	No	205.00- 205.91	No	No	No	Yes
			237.71- 238.76				
			238.79				
J0895	No	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (ICD-9-CM 733.01). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (ICD-9-CM 185) or adjuvant aromatase inhibitor therapy for breast cancer (ICD-9-CM 174.0-175.9). In men with non-metastatic prostate cancer, **Denosumab** also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J1050	٨	10y & up	٨	No	No	No	No
	J1050 is cover When billed for All facility fees same date of s	r family plannir for J1050 are	ng, an ICD fa	mily planning	diagnosis i	s required.	
J1060	No No	No.	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No
	Procedure cod				code from I	range 640 -	- 648.93 for
J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1162	No	No	972.1	No	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No
J1265	No	No	No	No	No	No	No

No

003

No

J1267

No

No

No

No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
.11270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below:

- A valid ICD-9-CM diagnosis from list 003 or a valid ICD-9-CM code of renal failure code range 584 through 586.
- Plus an ICD-9-CM diagnosis from the code range 787.20 through 787.29.

Plus an ICD-9-CM diagnosis of 588.81.

J1290*	No	16y & up	277.6	No	Yes	No	No
J1300	No	No	283.2	No	No	No	No
J1320	No	No	No	003	No	No	No
J1324	No	No	No	No	No	No	No
J1325	No	No	No	003	No	No	No
J1327	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1442	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1451	No	No	980.0- 980.1	No	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	277.5	No	Yes	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1556*	No	6y & up	279.06	No	Yes	No	Yes
NOTE:	Bivigam is an humoral immu administer at the should be door the illness and	nodeficiency. ne minimum in umented. A co	For patients a fusion rate pr implete histor	at risk for ren actical. Prev ry and physic	al dysfuncti rious treatm al exam do	on or throm ents with o	botic events, ther agents
J1557	No	2y & up	No	No	Yes	No	No
NOTE:	An ICD-9-CM	diagnosis code	that support	s medical ne	cessity is re	equired.	
J1559	No	4y & up	279.3	No	No	No	No
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	cal necessity	based on th	e ICD-9-CM	diagnosis	code billed.
J1566	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for medi	cal necessity	based on th	e ICD-9-CM	diagnosis	code billed.
J1568	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for medi	cal necessity	based on th	e ICD-9-CM	diagnosis	code billed.
J1569	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for medi	cal necessity	based on th	e ICD-9-CM	diagnosis	code billed.
J1570	No	No	No	003	No	No	No
J1571	No	No	No	No	No	No	No
J1572	No	No	No	No	No	No	No
J1573	No	No	No	No	No	No	No
J1580	No	No .	No	003	No	No	No
J1590	No	No	No	003	No	No	No
J1599*	No	4y & up	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for medi	cal necessity	based on th	e ICD-9-CM	diagnosis	code billed.
J1600	No	No	714.0- 714.9	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J1602*	No	18y & up	556.0- 556.9	No	Yes	No	Yes
			696.0 714.0-				
			714.9 721.9				

NOTE: Simponi is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- 1. Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.
- Active psoriatic arthritis alone or in combination with methotrexate that has failed Humira and Enbrel.
- 3. Active ankylosing spondylitis that has failed Humira and Enbrel.
- 4. Moderate to severe ulcerative colitis that has failed Humira.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	277.1	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No	No	003	No	No	No
J1670	No	No	No	003	No	No	No
J1700	No	No	No	003	No	No	No
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	No	16v & up	V23.41	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	277.5	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.



*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
.J1745*	No	No	Yes	No	Yes	No	Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD-9-CM diagnosis is 555.0, 555.1 or 555.9. No other diagnosis is required. All other diagnoses for beneficiaries under age 18 year require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

ICD-9-CM diagnosis code **555.9** as the primary detail diagnosis **AND** a secondary diagnosis of **565.1** or **569.81**

OR

ICD-9-CM diagnosis code range 556.0 - 556.9

OR

ICD-9-CM diagnosis code 696.0

OR

ICD-9-CM diagnosis code 714.0

ICD-9-CM diagnosis code **714.0** requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

OR

ICD-9-CM diagnosis code 724.9.

ICD-9-CM diagnosis code **724.9** requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No	No	No
J1756*	No	18y & up	285.21	No	Yes	No	Yes
J1786	No	2y & up	272.7	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	No	No	003	No	No	No
J1815	No	No	No	003	No	No	No

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	003	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	277.5	No	Yes	No	Yes
J1940	No	No	No	003	No	No	No
J1945	No	No	964.2	No	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No
J2210	No	No	No	003	No	No	No
J2248	No	No	No	No	No	No	No
J2250	No	No	No	003	No	No	No
J2260	No	No	428.0- 428.9	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical sho Prior Approva		se of multiple	sclerosis m	ust be sub	mitted with the
J2325	No	No	428.0- 428.9	No	No	No	No
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A	Prior Approv	al Letter is req	uired for a di	agnosis othe	r than a List	003 diagn	osis.
J2355	No	No	No	003	No	No	No
J2358	No	18y &up	No	003	No	No	No
J2360	No	No	No	003	No	No	No
J2370	No	No	No	003	No	No	No
J2400	No	No	No	003	No	No	No
J2405	No	No	No	003	No	No	No
J2410	No	No	No	003	No	No	No
J2425	No	No	No	003	No	No	No
J2426	No	18y & up	295.00- 295.95	No	No	No	No
J2430	No	No	No	003	No	No	No
J2440	No	No	No	003	No	No	No
J2460	No	No	No	003	No	No	No
J2469	No	No	No	003	No	No	No
J2501	No	No	No	No	No	No	No
J2503	No	No	362.50- 362.52	No	No	No	No
J2504	No	No	279.2	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedo Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2505	No	No	Yes	003	Yes	No	No
NOTE:	Procedure cod valid ICD-9-CN 202.80-202.88 V67.51, V58.1 (List 003). Dia	diagnosis cod, 288.00-288.0 1, V66.2 and E	de ranges 16 4, 288.09 or 933.1 are co	2.0-165.9 or 288.4 or 288 vered along v	174.0-175.9 .50-288.51 with a diagn	or 201.00 or 288.59,	-201.98 or 289.53, V58.69
J2507*	No	18y & up	274.00- 274.03	No	Yes	No	Yes
NOTE:	The submitted demonstrates to f disease or in settings and by Premedication after infusion.	that the benefic ntolerable side physicians pr should be adn	ciary has faile effects. This epared to ma ninistered and	ed all other tre drug should nage anaphy d the patient	eatments fo only be adm ylaxis and ir should be w	r gout due ministered i nfusion read vatched for	to progression in health care ctions. any reaction

J2510	No	No	No	003	No	No	No
J2513	No	No	No	No	No	No	No
J2515	No	No	No	003	No	No	No
J2540	No	No	No	003	No	No	No
J2543	No	No	No	003	No	No	No
J2550	No	No	No	003	No	No	No
J2560	No	No	No	003	No	No	No
J2562	No	21y & up	No	No	No	Yes	No

NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the 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.

J2590	No	No	No	003	No	. No	No
J2597	No	No	No	No	No	No	No
J2650	No	No	No	003	No	No	No
J2670	No	No	No	003	No	No	No
J2675	No	No	No	003	No	No	No
J2680	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2724	No	No	No	No	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	362.50 or 362.52	No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	287.31	No	No	No	No

NOTE: 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	714.0- 714.9	No	No	No	No
J2916	No	No	No	No	No	No	No
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2993	No	No	No	No	No	No	No
NOTE: For	the purpos	e of declotting	catheters, bi	II diagnosis 9	96.74 on th	e claim.	
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE: For	the purpos	e of declotting	catheters, bi	Il diagnosis 9	96.74 on th	e claim.	
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3060*	No	18y & up	272.7	No	Yes	No	Yes
J3070 J3095	No No	No 18y & up	No No	003	No No	No No	No No
	ease.						
J3101	No	21y & up	410.00 or	003	Yes	No	No
00101	140	Z I y & up	410.92	000	CS	140	
							NO
NOTE: Age	es 0-20 yea	rs have no res	trictions.	U			140
NOTE: Age	es 0-20 yea	rs have no res	trictions.	003	No	No	No
				003	No No	No No	
J3105	No	No	No				No
J3105 J3120	No No	No No	No No	003	No	No	No No
J3105 J3120 J3130	No No No	No No No	No No	003	No No	No No	No No No
J3105 J3120 J3130 J3140	No No No	No No No	No No No	003 003 003	No No	No No No	No No No
J3105 J3120 J3130 J3140 J3150	No No No No	No No No No	No No No No	003 003 003 003	No No No	No No No	No No No No
J3105 J3120 J3130 J3140 J3150 J3230	No No No No No	No No No No No	No No No No No	003 003 003 003 003	No No No No	No No No No	No No No No No
J3105 J3120 J3130 J3140 J3150 J3230 J3240	No No No No No No	No	No No No No No No No No No	003 003 003 003 003	No No No No No	No No No No No	No No No No No No
J3105 J3120 J3130 J3140 J3150 J3230 J3240 J3243	No	No	No	003 003 003 003 003 003 No	No No No No No No	No No No No No No	No No No No No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol). See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3262*	No	18v & up	714.0	No	Yes	No	Yes

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3285	No	No	416.0	No	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	No	No	003	No	No	No
J3357*	No	18y & up	696.1	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No
J3385*	No	4y & up	272.7	No	Yes	No	Yes

NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. 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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3396	No	No	115.02 or 115.12 or 115.92 or 360.21 or 362.50 or 362.52	No	Yes	No	No
J3400	No	No	No	003	No	No	No
J3410	No	No	No	003	No	No	No
J3420	No	No	281.0	No	No	No	No
J3430	No	No	No	003	No	No	No
J3465	No	No	No	No	No	No	No
NOTE: Pro	cedure cod	e J3465 is cov	ered for non-	pregnant ber	neficiaries.		
J3470	No	No	No	003	No	No	No
J3473	No	No	No	No	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No
J3485	No	No	No	003	No	No	No
J3489	No	No	174.0- 174.9 198.5 203.00 203.02 203.10 203.12 203.80 203.82 275.42 731.0 733.00- 733.09 OR 733.90	No	No	No	No

NOTE: Requires a paper claim form with the name of the drug, dosage and the route of administration for consideration for eligible beneficiaries. Clinical documentation may be required. See Section 252.111 for additional billing information.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3490	U9	16v & up	V23.41	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

J3520	No	No	No	003	No	No	No	
J7178	No	No	286.3	No	No	No	No	
J7180	No	2y & up	286.3	No	No	No	No	
J7183	No	No	286.4	No	No	No	No	
J7185	No	21y – 65y	No	No	No	No	No	
J7186	No	No	No	No	No	No	No	
J7187	No	No	No	No	No	No	No	
J7189	No	No	No	No	No	No	No	
J7190	No	No	No	No	No	No	No	
J7191	No	No	No	No	No	No	No	
J7192	No	No	No	No	No	No	No	
J7193	No	No	No	No	No	No	No	
J7194	No	No	No	No	No	No	No	
J7195	No	No	No	No	No	No	No	
J7196	No	18y & up	286.52- 286.59	No	No	No	No	
J7197	No	No	No	No	No	No	No	
J7198	No	No	No	No	No	No	No	
J7199*	No	No	No	No	No	No	No	

NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration. See Section 252.111 for billing instructions.

| J7300 | No | |
|-------|----|----|----|----|----|----|----|--|
| J7301 | No | |

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7302	No	No	617.0- 617.9 627.2 627.8	No	No	No	No
			OR 627.9				

NOTE: Covered for therapeutic use and treatment of heavy menstrual bleeding in women who have had a child or who have been pregnant.

			P 9				
J7303	No	No	No	No	No	No	No
J7306	No	No	No	No	No	No	No
J7307	No	No	No	No	No	No	No
J7308	No	No	No	003	No	No	No
J7310	No	No	No	003	No	No	No
J7311*	No	No	No	No	Yes	No	No
J7312*	No	18y &up	362.20 362.30 362.35 362.36 363.20	No	Yes	No	Yes

NOTE: Procedure code J7312 is covered for the allowable valid ICD-9 CM diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method. 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.

J7316* No 18y & up 379.27 No Yes No Yes

NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

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 **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. 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, 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. Refer to Section 245.031 for Prior Authorization.

	these injecti	ion procedures.	Refer to Se	ction 245.03	1 for Prior A	uthorization.	
J7330	No	No	No	No	No	Yes	No
NOTE:		code J7330 requ more information					See Section
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No
J7508	No	No	V42.0- V42.89	No	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
J7513	No	No	No	003	No	No	No
J7515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Proced Code	ure Modifie	r Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7520	No	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No	No
NOTE:		ation, procedur dosage and the			d on a pape	er claim for	m with the name
J7527	No	18y & up	V42.0	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE:	For consider of the drug, of instructions.	ation, procedure losage and the	e code J7599 route of admi	must be bille nistration. Se	d on a pape ee Section 2	er claim for 252.111 for	m with the name billing
J8530	No	No	No	003	No	No	No
J8650	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
J9000	No	No	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No
J9017	No	No	No	003	No	No	No
J9019*	No	2y-18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	205.00- 205.92	No	No	No	Yes
			238.71- 238.76 or				
			238.79				
J9027	No	1y to 20y	204.00 or 204.01	No	No	No	No
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	200.30- 200.48	No	Yes	No	Yes
			202.00- 202.08				
			203.00				
			203.10				
			203.80				
			204.10- 204.12 or 238.6				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol). See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9035*	No	No	153.0- 154.8	No	Yes	No	Yes
			162.0- 162.9				
			174.0- 175.9 or				
			189.0- 189.9				
J9040	No	No	No	003	No	No	No
J9041*	No	No	203.00- 203.82	No	Yes	No	Yes
			200.40- 200.48				
J9042*	No	18y & up	200.60- 200.68,	No	Yes	No	Yes
			201.00- 201.98				

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, ICD-9-CM diagnosis 200.6 after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043* No 18y & up 185.0 No Yes No Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9047*	No	18y & up	203.00- 203.02	No	Yes	No	Yes

NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.

J9050	No	No	No	003	No	No	No
J9055*	No	No	140.0- 149.9	No	Yes	No	Yes
			153.0- 154.8				
			160.0- 161.9)_			
			171.0				
			172.0- 172.4		0		
			173.00- 173.49		3 ′^		
			OR				
			195.0				
J9060	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9098	No	No	No	003	Yes	No	No
J9100	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9155	No	21y & up	No	003	No	No	No
NOTE: (Covered for	male beneficiar	ies only.				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9160	No	No	201.10- 202.18	No	Yes	No	Yes
			202.20- 202.28				
			OR				
			202.80- 202.88				
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	150.0- 150.8	003	Yes	No	Yes
			151.0- 151.9				
			162.0- 162.9)_			
			171.0- 171.9				
			174.0- 175.9				
			183.0				
			200.00- 200.88				
			Or				
			202.00- 202.98				
J9179*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

J9181	No	No	No	003	No	No	No
J9185	No	No	No	003	No	No	No
J9190	No	No	No	003	No	No	No
J9200	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	174.0- 175.9	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	185 198.82 or V10.46	No	No	No	No

NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.

J9225	No	No	185	No	No	No	No	
J9226*	No	0-12v	259.1	No	Yes	No	Yes	

NOTE: Supprelin LA: Prior to initiation of treatment, a clinical diagnosis of CPP, ICD-9-CM code 259.1, should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor) and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with history and physical examination when requesting prior approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9228*	No	18y & up	172.0- 172.9	No	Yes	No	Yes

NOTE: Ipilimumab is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilimumab. Ipilimumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilimumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilimumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

	_						
J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	202.80- 202.88 or	No	Yes	No	Yes
			204.00- 208.92				

NOTE: The disease must have not responded to, or either has relapsed, following treatment with at least 2 chemotherapy regimens.

J9262*	No	18y & up	205.10- 205.12	No	Yes	No	No

NOTE: Synribo is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.

J9263*	No	No	151.0- 151.9	No	Yes	No	Yes
			153.0- 154.8				
			183.0- 183.9 and				
			202.00- 202.98				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9264*	No	No	140.0- 149.9	No	Yes	No	Yes
			154.2- 154.3				
			157.0- 157.3				
			157.8				
			157.9				
			158.8				
			160.0- 162.9				
		(174.0- 175.9				
			183.0- 183,9				
			195.0				
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No
J9293	No	No	Yes	No	Yes	No	No
NOTE: R	equires ICD-9	9-CM diagnosis	s code for ca	ncer or ICD-9	9-CM diagno	osis code o	of 340.
J9300	No	No	No	003	No	No	No
J9303*	No	No	153.0- 154.8	No	Yes	No	Yes
J9305*	No	No	162.0- 163.9	No	Yes	No	Yes
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Perjeta** is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with tratuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.

J9307	No	18y & up	No	003	No	No	No	
00007	110	10у а ир	140	000	110	110	110	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9310	No	No	No	003	No	No	No
J9315	No	18y & up	No	003	No	No	No
J9320	No	No	No	003	No	No	No
J9328*	No	21y & up	191.0- 191.9	No	Yes	No	Yes

NOTE: The diagnosis must be for:

Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	189.0- 189.1	No	No	No	No
J9340	No	No	No	003	No	No	No
J9351	No	18y & up	No	003	No	No	No
J9354*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **traztuzumab** and a **taxane**, separately or in combination. Patients should have either:

received prior therapy for metastatic disease,

OR

2. developed disease recurrence during or within six months of completing adjuvant therapy.

All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.

J9355	No	No	No	003	No	No	No
J9357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9371*	No	18y & up	204.00- 204.02	No	Yes	No	Yes
	Marqibo is a vectoromosome rewhose disease history and phy Approval will be	negative (Ph-) a has progresso ysical exam do	acute lympho ed following t cumenting al	blastic leuke wo or more a	mia in seco anti-leukemi	nd or great c therapies	er relapse or a. A complete
J9390	No	No	No	003	No	No	No
J9395*	No	No	174.0- 175.9	No	Yes	No	Yes
J9400*	No	18y & up	153.0- 154.8	No	Yes	No	Yes
	This procedure (mCRC), that is complete histo patient has bee	s resistant to o ry and physica	r has progres I exam docur	sed following	g an oxalipla	atin-contair	ning regimen.
J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No
NOTE:	See Section 25	52.111 in this n	nanual for co	verage inform	nation.		
P9012*	No	No	No	No	No	No	No
	Attach the mar information.	nufacturer's inv	oice to the cl	aim. See Se	ection 272.4	43 for addi	tional
P9041	No	No	No	No	No	No	No
P9045	No	No	No	No	No	No	No
P9046	No	No	No	No	No	No	No
P9047	No	No	No	No	No	No	No
Q0139	No	No	584.5- 586.0	No	No	No	No
Q0162	UB	4y & up	No	No	No	No	No
NOTE:	Q0162-UB rep	resents "Onda	nsetron 1 mg	, oral" billable	e electronica	ally or on p	aper.
Q0166	UB	No	No	003	No	No	No
	Use UB modific Medicaid descr		"Granistron F	ICI tab 1 mg,	oral" (Kytr	il). This is	the Arkansas
Q2009	No	No	No	003	No	No	No
Q2017	No	No	No	003	No	No	No
Q2034	No	18y & up	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q2043*	No	18y & up	185	No	Yes	No	Yes

NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.

Q2049	No	18y & up	No	003	No	No	No
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4081	No	No	584.5- 586	No	No	No	No
Q4101	No	No	No	No	No	No	No
Q4102	No	No	No	No	No	No	No
Q4103	No	No	No	No	No	No	No
Q4104	No	No	No	No	No	No	No
Q4105	No	No	No	No	No	No	No
Q4106	No	No	No	No	No	No	No
Q4107	No	No	No	No	No	No	No
Q4108	No	No	No	No	No	No	No
Q4110	No	No	No	No	No	No	No
Q4111	No	No	No	No	No	No	No
Q4112	No	No	No	No	Yes	No	No
Q4113	No	No	No	No	Yes	No	No
Q4114	No	No	No	No	Yes	No	No
Q4116	No	No	174.0- 175.9	No	No	No	No
Q4121	No	No	No	No	No	No	No
Q4124	No	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No	No
NOTE:	Attach the n	nanufacturer's i	nvoice to the	claim.			
Q4145*	No	No	No	No	No	No	No
NOTE:	Attach the n	nanufacturer's i	nvoice to the	claim.			

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q9969	No	No	No	No	No	No	No
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
S0032	No	No	No	003	No	No	No
S0034	No	No	No	003	No	No	No
S0039	No	No	No	003	No	No	No
S0040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
S0077	No	No	No	003	No	No	No
S0078	No	No	No	003	No	Yes	No
S0080	No	No	No	003	No	No	No
S0081	No	No	No	003	No	No	No
S0092	No .	No	No	003	No	No	No
S0093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
S0119	No	4y & up	No	No	No	No	No
S0145	No	No	070.54	No	No	No	No
30164	No	No	No	003	No	No	No
30177	No	No	No	003	No	No	No
S0179	No	No	No	003	No	No	No
S0187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No
NOTE: I	Procedure code	e Z1847 is for	Torecan 10 n	ng oral tablet	s. Limit of ((4) 10 mg ta	abs per day.
90375*	No	No	No	No	No	No	No
8	Each date of sealong with the danatomical site	clinical adminis and route of a	stration record	ds indicating	medical ne	cessity, dos	sage,

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 271.003 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Proced Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90376*	No	No	No	No	No	No	No
NOTE:	Each date of s along with the anatomical site administration	clinical adminise and route of a	stration recor	ds indicating	medical ne	cessity, do	sage,
90385	No	No	No	No	No	No	No
NOTE:	Procedure cod	le 90385 is lim	ited to one in	jection per pr	egnancy.		
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose	and attach the	manufacture	r's invoice to	the claim.		
90632	No	19y & up	No	No	No	No	No
90662	No	65y & up	No	No	No	No	No
NOTE:	Procedure cod service on or a			eficiaries age	es 65 years	and older f	or dates of
90673	No	19y-49y	No	No	No	No	No
90675*	No	No	No	No	No	No	No
NOTE:	Procedure cod paper claims we date of service must be identification. Reimbu	vith procedure e. If date spans fied for each da	code and dos s are used, a ate within the	sage entered ppropriate un span. Attacl	in claim for lits of service h the manuf	m CMS-14 e must be	50 for each indicated and
90676*	No	No	No	No	No	No	No
NOTE:	Procedure cod paper claims w date of service must be identifical. Reimbu	vith procedure e. If date spans fied for each da	code and dos s are used, a ate within the	sage entered ppropriate un span. Attacl	in claim for lits of service th the manuf	m CMS-14 e must be	50 for each indicated and
90690	No	6y & up	No	No	No	No	No
90691	No	3y & up	No	No	No	No	No
	No	No	No	No	No	No	No
90703		1y & up	No	No	No	No	No
90703 90704	No	· y a ap					
	No No	1y & up	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90707	U1	21y - 44y	No	No	No	No	No
t	hrough 44, wh	e 90707 is pay no may be at ris ifetime. U1 mo	sk of exposui	re to these di	seases. Co	dbearing a	ge, ages 21 imited to two (2
90707	No	19y – 20y	No	No	No	No	No
90708	No	9m & up	No	No No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: A	Attach the man	nufacturer's inv	oice to the cl	aim.			
90732	No	2y & up	No	No	No	No	No
		1 years and ok h risk. All ben					
90733	No	No	No	No	No	No	No
90735	No	0 – 20y	No	No	No	No	No
90736	No	60y & up	No	No	No	No	No
NOTE: Zo	oster vaccine is	benefit limited	to once in a	ifetime.			
90740	No	No	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
96379*	No	No	No	No	No	No	No
p	provided (drug	r procedure co , dose, route o uding documer	f administrati	on) as well a	s clinical no		of the service ing the

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

MARK-UP

TOC not required

272.102

Drug Procedure Codes and National Drug Codes (NDC)

5-17-1010-1-15

Effective for claims with dates of service on or after JulyJanuary 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Health-Ccare Financing Administration-Common Procedure Codeing 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 at https://arkansas.magellanrx.com/provider/documents.

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 Labelerswebsite. 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
00123	0456	/0

LABELER	PRODUCT CODE	PACKAGE CODE
CODE	(4 digits)	(2 digits)
(5 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

	Required 11-digit NDC
10-digit FDA NDC on PACKAGE	(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 HCPCS/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.

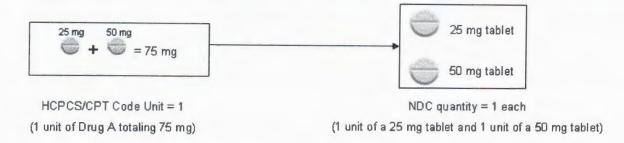
Exception: There is no requirement for an NDC when billing for vaccines.

C. Claims Filing

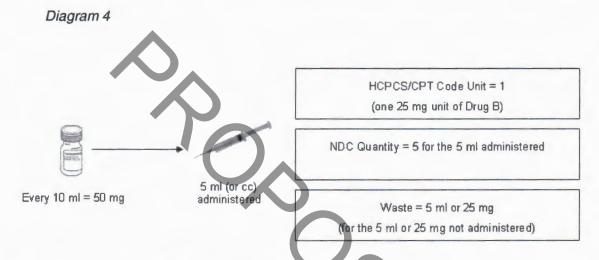
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 43.

Diagram 3



Example 2: If 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.



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 https://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

		42-MICE CS. 45-SEE CANFIER	ALPOPOS BASE HIPPO SODE	de source source of down coarse	47100 Junitable	49 HOR-COMEMBO CHANNE
	Sequence 1	0636 N4 12345878912 UN 1 00	21234	08/01/07 1	2500	
	Seguence 2	0636 N4 01111222233 UN 1 00	Z1234	08/01/07 0	0 00	
Detail 2		0305 Hemogram	85025	08/01/07 1	55 00	Wetcorre
	Sequence 1	0636 N4 44444555688 UN 5 00	76789	08/01/07 1	21.00	

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.

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.

JI. 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.

See Section 272.510 for additional information regarding National Drug Code (NDC) billing.

272.510 Injections, Radiopharmaceuticals and Therapeutic Agents
1-15-15101-15

Intravenous administration of therapeutic agents is payable only if provided in an outpatient setting. Therapeutic injections should only be provided by facilities that have the capacity to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Reimbursement for supplies is included in the administration fee. Use procedure code 96365 for IV infusion therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code 0760 (for observation), up to 8 hours maximum per day. For monoclonal antibody intravenous infusion use procedure code 76403.

Multiple units may be billed for drug procedure codes, if appropriate. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as take home drugs.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

- Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
- Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
- 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
- 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 272.102 for additional information regarding National Drug Code (NDC) billing.

See Section 272.450 for special billing instructions and coverage of Radiopharmaceuticals.

For coverage information regarding any drug not listed, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

The following is a list of injections with special instructions for coverage and billing:

Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- 1. The first column of the list contains the CPT or HCPCS procedure codes.
- The <u>second</u> column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
- 3. The <u>third</u> 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).
- 4. The **fourth** column indicates specific ICD-9-CM primary diagnosis restrictions.
- The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
- The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 241.000 for prior authorization.)
- 8. The <u>eighth</u> 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. (See Section 272.103 for Prior Approval.) <u>View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services.</u>

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter	
A9520	No	18y & up	172.0- 175.9	No	No	No	No	
A9542*	No	No	No	No	No	No	Yes	
A9543*	No	No	No	No	No	No	Yes	
A9544*	No	No	No	No	No	No	Yes	
A9545*	No No		No	No	No	No	Yes	
sta	ted. Treatm	5 require the F nent failures the xamination mu	at the patient	previously ex				
A9547*	No	No	No	No	No	No	Yes	
prov subi not	rided. To ob- mitted along diagnostic.	required before tain Prior Appro with a report of	oval, a copy of the ultrasoun	the patient's d or compute	history and rized axial to	physical ex- omography	am must be (CAT) that was	
A9555*	No	No	No	No	No	No	No	
		Approval, a co						
dia	gnostic and	g with a report attach a copy	of the manuf	acturer's invo	oice to the c	laim.		
							No	
dia A9557	gnostic and	attach a copy	of the manuf	acturer's invo	oice to the c	laim.		
dia A9557 A9559*	No No	No No	of the manuf 430- 434.91 281.0	No No	No No	No	No	
dia A9557 A9559* NOTE: Att	No No	No No	of the manuf 430- 434.91 281.0	No No	No No	No	No	
dia A9557 A9559*	No No ach the mar	No No nufacturer's inv	of the manuf 430- 434.91 281.0 roice to the cl	No No No aim.	No No	No	No No	
dia A9557 A9559* NOTE: Att A9563 A9575	No No ach the mar	No No No nufacturer's inv	of the manuf 430- 434.91 281.0 roice to the cl	No No aim.	No No	No No No	No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580*	No No ach the mar No No No	No No No nufacturer's inv No 2y& up	of the manuf 430- 434.91 281.0 roice to the cl 238.4 No 198.5	No No No No No No No No	No No No	No No No No No	No No No	
A9557 A9559* NOTE: Att A9563 A9575 A9580*	No No ach the mar No No No	No No No nufacturer's inv No 2y& up No	of the manuf 430- 434.91 281.0 roice to the cl 238.4 No 198.5	No No No No No No No No	No No No	No No No No No	No No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580*	No No ach the mar No No No ach the mar	No No No No No No No 2y& up No nufacturer's inv	of the manuford 430-434.91 281.0 roice to the classical 238.4 No 198.5 roice to the classical 238.5	No N	No No No No No No	No No No No No No	No No No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580* NOTE: Att A9581	No N	No No No No No No 2y& up No nufacturer's inv	of the manuford 430-434.91 281.0 roice to the classical and the cl	No N	No No No No No No No No	No No No No No No No	No No No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580* NOTE: Att A9581 A9582* NOTE: Att	No N	No No No No No No 2y& up No nufacturer's inv 21y & up No	of the manuford 430-434.91 281.0 roice to the classical and the cl	No N	No No No No No No No No	No No No No No No No	No No No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580* NOTE: Att A9581 A9582* NOTE: Att A9585*	No Ach the mar No No Ach the mar	No No No No No 2y& up No nufacturer's inv 21y & up No nufacturer's inv	of the manuformation of the ma	No aim. No No No aim.	No No No No No No No No	No No No No No No No No	No No No No No No	
dia A9557 A9559* NOTE: Att A9563 A9575 A9580* NOTE: Att A9582* NOTE: Att	No Ach the mar No	Attach a copy No No nufacturer's inv No 2y& up No nufacturer's inv 21y & up No nufacturer's inv 21y & up	of the manuformation of the manuformation of the manuformation of the manuformation of the classical states of the classical s	No N	No	No	No No No No No No No No	
A9557 A9559* NOTE: Att A9563 A9575 A9580* NOTE: Att A9581 A9582* NOTE: Att A9585* A9586*	No Ach the mar No	No No No No No No 2y& up No nufacturer's inv 21y & up No nufacturer's inv 21y & up No nufacturer's inv 21y & up	of the manuformation of the manuformation of the manuformation of the manuformation of the classical states of the classical s	No N	No	No	No No No No No No No No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C1841*	No	No	362.74	No	No	No	No
NOTE: Attac	ch the manu	facturer's invoi	ce to the clain	٦.			
C8931	No	No	No	No	No	No	No
C8932	No	No	No	No	No	No	No
C8934	No	No	No	No	No	No	No
C8935	No	No	No	No	No	No	No
C8936	No	No	No	No	No	No	No
C9132	No	18y & up	286.7	No	Yes	No	No

NOTE: Kcentra is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. Kcentra is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to Kcentra should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9133	No	18y & up	No	No	No	No	No
C9248	No	No	No	No	No	No	No
C9254	No	18y & up	No	No	No	No	No
C9256	No	No	No	No	No	No	No
C9257*	No	21y & up	Yes	No	Yes	No	Yes

NOTE: Coverage of procedure code C9257 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 Fluoroscein angiogram or OCT, patient screen for conditions that would contraindicate the use of **Avastin**, and documentation of patient consent.

C9363	No	No	940.00- 949.50	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9441	No	18y & up	280.0- 280.9	No	No	No	No
			AND				
			285.1				
			OR				
			585.1- 585.9				

NOTE: Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

C9733	No	No	No	No	No	No	No
C9734	No	No	No	No	No	No	No
J0120	No	No	No	003	No	No	No
J0129*	No	No	714.0- 714.2	No	No	No	Yes

NOTE: Patient must have had inadequate response to one or more disease-modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam
showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic
drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis,
etc.

J0130	No	No	No	003	No	No	No
J0132	No	No	965.4	No	No	No	No
J0133	No	No	053.0- 054.9	No	No	No	No
J0150	No	No	No	No	No	No	No
NOTE:	Maximum u	nits allowed a	are 4 per day.				
J0151	No	No	No	No	No	No	No
J0171	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0178*	No	18v & up	362.52	No	Yes	No	Yes

NOTE: Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.

J0180*	No	No	272.7	No	No	No	Yes
J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	No	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	271.0	No	No	No	Yes

NOTE: Evaluation by a physician with a specialty in clinical genetics documenting progress required annually.

J0221* No No 271.0 No Yes No Yes

NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile, Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme 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 FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.

IOOFO	Ma	Al-	070 4	Ma	Ma	Ma	Ma	
J0256	No	No	273.4	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0257	No	18y & up	273.4	No	No	No	No

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to alpha 1 proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No	
J0280	No	No	No	003	No	No	No	
J0282	No	No	No	003	No	No	No	
J0285	No	No	No	003	No	No	No	
J0287	No	No	No	003	No	No	No	
J0288	No	No	No	003	No	No	Ņo	
J0289	No	No	No	003	No	No	No	
J0290	No	No	No	003	No	No	No	
J0295	No	No	No	003	No	No	No	
J0300	No	No	No	003	No	No	No	
J0330	No	No	No	003	No	No	No	
J0348	No	No	Yes	003	No	No	No	

NOTE: Procedure code J0348 is valid for any condition below, along with ICD-9-CM diagnosis code of 112.5 or 112.8 (and any valid 5th digits), or 112.9 (1) End-stage Renal Disease (ICD-9-CM codes 584 – 586) or (2) AIDS or cancer (List 003) or (3) Post transplant status (i.e., ICD-9-CM diagnosis code 986.80-996.89) or specify transplanted organ and transplant date.

J0350	No	No	No	003	No	No	No
J0360	No	No	No	003	No	No	No
J0364	No	No	No	No	No	No	No
J0380	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0390	No	No	No	003	No	No	No
J0400	No	No	No	No	No	No	No
J0401	No	13y & up	295.00- 295.95	No	No	No	No
J0456	No	No	No	003	No	No	No
J0461	No	No	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	V42.0	No	No	No	No
J0485	No	18y & up	V42.0	No	No	No	No
J0490*	No	18y & up	695.4	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.

	_			_			
J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is re	eviewed for med	dical neces	sity based on	ICD-9-CM d	iagnosis cod	e.
J0586	No	No	No	No	Yes	No	No
NOTE:	This proced code billed.	ure code is revi	ewed for m	edical necess	sity based on	an ICD-9-Cl	M diagnosis
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD-9-C	M diagnosis cod	de which su	upports medic	al necessity	is required.	
J0592	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0595	No	No	No	003	No	No	No
J0597*	No	13y & up	277.6	No	Yes	No	No
	nis code will l ibmitted.	oe reviewed fo	r medical ned	cessity based	on the clin	ical docum	entation
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
J0630	No	No	No	003	No	No	No
J0636	No	No	584-586	No	No	No	No
J0637*	No	No	No	No	Yes	No	No

NOTE: Procedure code J0637 is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage. After 30 days of use, an updated medical exam and history must be submitted.

J0638	No	4y &up	277.31	No	No	No	No	
J0640	No	No	No	003	No	No	No	
J0641*	No	No	170.0- 170.9	No	Yes	No	Yes	

NOTE: Approved Only:

After high methotrexate therapy in osteosarcoma

OF

To diminish the toxicity and counteract the effects of impaired methotrexate elimination and of inadvertent over dosage of folic acid antagonists.

J0670	No	No	No	003	No	No	No
J0690	No	No	No	003	No	No	No
J0692	No	No	No	003	No	No	No
J0694	No	No	No	003	No	No	No
J0696	No	No	No	003	No	No	No
J0697	No	No	No	003	No	No	No
J0698	No	No	No	003	No	No	No
J0702	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code from range 640 – 648.93 for complications of pregnancy or List 003 for all ages.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0706	No	No	No	003	No	No	No
J0710	No	No	No	003	No	No	No
J0712	No	18y & up	No	No	No	No	No
J0713	No	No	No	003	No	No	No
J0715	No	No	No	003	No	No	No
J0716	No	No	989.5	No	No	No	No
J0717*	No	18y & up	555.0- 555.9	No	Yes	No	Yes

714.0

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (Cimzia) 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 corticosteroids or 6-mercaptopurine/azathioprine.

OR

For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed Enbrel and Humira.

J0720	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J0725	No	No	No	003	No	No	No
J0735	No	No	No	003	No	No	No
J0740	No	No	No	003	No	No	No
J0743	No	No	No	003	No	No	No
J0744	No	No	No	003	No	No	No
J0745	No	No	No	003	No	No	No
J0760	No	No	No	003	No	No	No
J0770	No	No	No	003	No	No	No
J0780	No	No	No	003	No	No	No
J0795	No	No	No	003	No	No	No
J0800	No	No	No	003	No	No	No
J0833	No	No	No	No	No	No	No
J0834	No	No	No	No	No	No	No
J0850	No	No	No	003	No	No	No
J0878	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881	No	No	Yes; see	No	No	No	No

NOTE: For all diagnoses, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

In addition to the primary diagnosis, an ICD-9-CM diagnosis code from each column below must be billed on the claim.

Column I	Column	II
	Code	Description
285.9 Secondary Anemia	V58.11	Encounter for antineoplastic chemotherapy
'()	V67.2	Following chemotherapy
	E933.1	Antineoplastic and immunosuppressive drugs

Use ICD-9-CM code **285.29** (primary) with **070.54**, **238.72-238.75** or **714.0-714.4** (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

Column II				
Code	Description			
070.54	Chronic Hepatitis C without mention of coma			
238.72- 238.75	Myelodysplastic			
714.0- 714.4	Rheumatoid Arthritis			
	Code 070.54 238.72- 238.75 714.0-			

J0882	NO	INO	584-586	140	INO	INO	INO
J0885							
NOTE:		ure code J088 e ICD-9-CM 2		n for speci	ific criteria. W	hen the ben	eficiary is not on
J0886	No	No	584-586	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0894*	No	No	205.00- 205.91	No	No	No	Yes
			237.71- 238.76				
			238.79				
J0895	No	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (ICD-9-CM 733.01). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (ICD-9-CM 185) or adjuvant aromatase inhibitor therapy for breast cancer (ICD-9-CM 174.0-175.9). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why **Zometa** cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	٨	10y & up	٨	No	No	No	No

J1050 is covered for therapeutic and family planning services for non-sterile females only. When billed for family planning, an ICD family planning diagnosis is required.

All facility fees for **J1050** are bundled under the surgical procedure code if performed on the same date of service.

J1060	No	No	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code from range 640 – 648.93 for complications of pregnancy or List 003 for all ages.

	omplication	is of prograd	icy of List 000	ioi all'ages.			
J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1162	No	No	972.1	No	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No
J1265	No	No	No	No	No	No	No
J1267	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol)

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below:

- A valid ICD-9-CM diagnosis from list 003 or a valid ICD-9-CM code of renal failure code range 584 through 586.
- Plus an ICD-9-CM diagnosis from the code range 787.20 through 787.29.
- Plus an ICD-9-CM diagnosis of 588.81.

J1290*	No	16y & up	277.6	No	Yes	No	No
J1300	No	No	283.2	No	No	No	No
J1320	No	No	No	003	No	No	No
J1324	No	No	No	No	No	No	No
J1325	No	No	No	003	No	No	No
J1327	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1442	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1451	No	No	980.0- 980.1	No	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	277.5	No	Yes	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1556*	No	6y & up	279.06	No	Yes	No	Yes
NOTE:	humoral immu administer at t should be doc	immune globu nodeficiency. he minimum in umented. A co I prior treatmer	For patients fusion rate pomplete histo	at risk for ren ractical. Prev ry and physic	al dysfuncti vious treatm al exam do	on or throm ents with o	botic events, ther agents
J1557	No	2y & up	No	No	Yes	No	No
NOTE:	An ICD-9-CM	diagnosis code	that support	ts medical ne	cessity is re	equired.	
J1559	No	4y & up	279.3	No	No	No	No
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	viewed for med	ical necessit	based on th	e ICD-9-CN	diagnosis	code billed.
J1566	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	viewed for med	ical necessity	based on th	e ICD-9-CN	diagnosis	code billed.
J1568	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	viewed for med	ical necessity	based on th	e ICD-9-CN	diagnosis	code billed.
J1569	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	viewed for med	ical necessity	based on th	e ICD-9-CN	diagnosis	code billed.
J1570	No	No	No	003	No	No	No
J1571	No	No	No	No	No	No	No
J1572	No	No	No	No	No	No	No
J1573	No	No	No	No	No	No	No
J1580	No	No	No	003	No	No	No
J1590	No	No	No	003	No	No	No
J1599*	No	4y & up	No	No	Yes	No	No
NOTE:	Claims are rev	viewed for med	ical necessity	based on th	e ICD-9-CN	diagnosis	code billed.
J1600	No	No	714.0- 714.9	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1602*	No	18y & up	556.0- 556.9	No	Yes	No	Yes
			696.0				
			714.0-				
			714.9				
			721.9				

NOTE: Simponi is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed Humira and Enbrel.
- 2. Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 3. Active ankylosing spondylitis that has failed **Humira** and **Enbrel**.
- 4. Moderate to severe ulcerative colitis that has failed Humira.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	277.1	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No	No	003	No	No	No
J1670	No	No	No	003	No	No	No
J1700	No	No	No	003	No	No	No
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	No	16y & up	V23.41	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	277.5	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.



^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1745*	No	No	Yes	No	Yes	No	Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD-9-CM diagnosis **is 555.0**, **555.1** or **555.9**. No other diagnosis is required. All other diagnoses for beneficiaries under age 18 year require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

ICD-9-CM diagnosis code **555.9** as the primary detail diagnosis **AND** a secondary diagnosis of **565.1** or **569.81**

OR

ICD-9-CM diagnosis code range 556.0 - 556.9

OR

ICD-9-CM diagnosis code 696.0

OR

ICD-9-CM diagnosis code 714.0

ICD-9-CM diagnosis code **714.0** requires a **Prior** Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

OR

ICD-9-CM diagnosis code 724.9.

ICD-9-CM diagnosis code **724.9** requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No	No	No
J1756*	No	18y & up	285.21	No	Yes	No	Yes
J1786	No	2y & up	272.7	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	No	No	003	No	No	No
J1815	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	003	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	277.5	No	Yes	No	Yes
J1940	No	No	No	003	No	No	No
J1945	No	No	964.2	No	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No
J2210	No	No	No	003	No	No	No
J2248	No	No	No	No	No	No	No
J2250	No	No	No	003	No	No	No
J2260	No	No	428.0- 428.9	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol). See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical show Prior Approva		e of multiple	sclerosis m	ust be subi	mitted with the
J2325	No	No	428.0- 428.9	No	No	No	No
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A	Prior Approv	al Letter is req	uired for a di	agnosis othe	r than a List	003 diagn	osis.
J2355	No	No	No	003	No	No	No
J2358	No	18y &up	No	003	No	No	No
J2360	No	No	No	003	No	No	No
J2370	No	No	No	003	No	No	No
J2400	No	No	No	003	No	No	No
J2405	No	No	No	003	No	No	No
J2410	No	No	No	003	No	No	No
J2425	No	No	No	003	No	No	No
J2426	No	18y & up	295.00- 295.95	No	No	No	No
J2430	No	No	No	003	No	No	No
J2440	No	No	No	003	No	No	No
J2460	No	No	No	003	No	No	No
J2469	No	No	No	003	No	No	No
J2501	No	No	No	No	No	No	No
J2503	No	No	362.50- 362.52	No	No	No	No
J2504	No	No	279.2	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

No

No No

No

J2650

J2670

J2675

J2680

No

003

003

003

003

No

No

No

No

No

No

No

No

protocol).
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2505	No	No	Yes	003	Yes	No	No
va 20 V6	lid ICD-9-CN 2.80-202.88 7.51, V58.1	e J2505 is pay d diagnosis coo , 288.00-288.0 1, V66.2 and E gnosis codes r	de ranges 16 4, 288.09 or 933.1 are co	2.0-165.9 or 288.4 or 288 vered along v	174.0-175.9 .50-288.51 with a diagn	or 201.00- or 288.59, 2	201.98 or 289.53, V58.69
J2507*	No	18y & up	274.00- 274.03	No	Yes	No	Yes
de of se Pr	monstrates to disease or in ttings and by emedication	medical documentation that the benefication to lead to the benefication of the benefic	clary has faile effects. This epared to ma ninistered and	ed all other tro s drug should anage anaphy d the patient	eatments fo only be adi ylaxis and ir should be v	r gout due in ministered in fusion read vatched for	to progression n health care ctions.
J2510	No	No	No	003	No	No	No
J2513	No	No	No	No	No	No	No
J2515	No	No	No	003	No	No	No
J2540	No	No	No	003	No	No	No
J2543	No	No	No	003	No	No	No
J2550	No	No	No	003	No	No	No
J2560	No	No	No	003	No	No	No
J25 6 2	No	21y & up	No	No	No	Yes	No
au be gra su mu ap co do	thorization by provided by anulocyte-co bsequent au ultiple myelor proved by Anventional th	e J2562 is cov y the Arkansas a telephone re lony stimulatin tologous trans ma. Applicants FMC. There merapy for cons ly, times four d request.	s Foundation eview. Appropriately factor to moplantation in swill only be nust be docurtideration of t	for Medical Coval is granted obilize hemat patients with considered for mentation of this drug. The	Care (AFMC d in conjunct topoietic ste Non-Hodgk or approval failure to mo e drug will d	c). Prior au tion with the m cells for in's lympho if a transplate obilize cells only be appl	thorization will e use of collection and ma and ant has been with roved for four
-111		7					
12590	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2724	No	No	No	No	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	362.50 or 362.52	No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	287.31	No	No	No	No

NOTE: 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	714.0- 714.9	No	No	No	No
J2916	No	No	No	No	No	No	No
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2993	No	No	No	No	No	No	No
NOTE: For	the purpos	e of declotting	catheters, bi	II diagnosis 9	96.74 on th	e claim.	
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE: For	the purpos	e of declotting	catheters, bi	II diagnosis 9	96.74 on th	e claim.	
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3060*	No	18y & up	272.7	No	Yes	No	Yes
This		sical exam with tinclude the pr					
	No	No	No	003	No	No	No
J3070		No 18y & up	No No	003	No No	No No	No No
J3070 J3095 J3101	No						
J3070 J3095 J3101	No No No	18y & up	No 410.00 or 410.92	003	No	No	No
J3070 J3095 J3101 NOTE: Age	No No No	18y & up 21y & up	No 410.00 or 410.92	003	No	No	No
J3070 J3095 J3101 NOTE: Age J3105	No No No es 0-20 yea	18y & up 21y & up rs have no res	No 410.00 or 410.92 trictions.	003	No	No No	No No
J3070 J3095 J3101 NOTE: Age J3105 J3120	No No No es 0-20 yea	18y & up 21y & up rs have no res	No 410.00 or 410.92 trictions.	003	No Yes	No No	No No
J3070 J3095 J3101	No No No es 0-20 yea No	18y & up 21y & up rs have no res	No 410.00 or 410.92 trictions. No	003 003 003 003	No Yes No	No No No	No No No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130	No No No es 0-20 yea No No	18y & up 21y & up rs have no res	No 410.00 or 410.92 trictions. No No	003 003 003 003 003	No Yes No No	No No No No	No No No No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130 J3140 J3150	No No No es 0-20 yea No No No	18y & up 21y & up rs have no resi No No No No	No 410.00 or 410.92 trictions. No No No No	003 003 003 003 003 003	No Yes No No No	No No No No No	No No No No No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130 J3140	No No No es 0-20 yea No No No No	18y & up 21y & up rs have no res No No No No No	No 410.00 or 410.92 trictions. No No No No No	003 003 003 003 003 003	No Yes No No No No	No No No No No	No No No No No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130 J3140 J3150 J3230	No	18y & up 21y & up rs have no resi No No No No No No No	No 410.00 or 410.92 trictions. No No No No No No No	003 003 003 003 003 003 003	No Yes No No No No No No No	No No No No No No	No No No No No No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130 J3140 J3150 J3230 J3240	No N	18y & up 21y & up rs have no res No No No No No No No No No	No 410.00 or 410.92 trictions. No	003 003 003 003 003 003 003 003	No Yes No	No No No No No No	No
J3070 J3095 J3101 NOTE: Age J3105 J3120 J3130 J3140 J3150 J3230 J3240 J3243	No N	18y & up 21y & up rs have no resi No	No 410.00 or 410.92 trictions. No	003 003 003 003 003 003 003 003 No	No Yes No	No No No No No No No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).
See Section 241.000 for prior authorization procedures.
See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3262*	No	18v & up	714.0	No	Yes	No	Yes

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3285	No	No	416.0	No	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	No	No	003	No	No	No
J3357*	No	18y & up	696.1	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No
J3385*	No	4y & up	272.7	No	Yes	No	Yes

NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. 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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3396	No	No	115.02 or 115.12 or 115.92 or 360.21 or 362.50 or 362.52	No	Yes	No	No
J3400	No	No	No	003	No	No	No
J3410	No	No	No	003	No	No	No
J3420	No	No	281.0	No	No	No	No
J3430	No	No	No	003	No	No	No
J3465	No	No	No	No	No	No	No
NOTE: Pro	cedure cod	e J3465 is c ov	ered for non-	pregnant ber	neficiaries.		
J3470	No	No	No	003	No	No	No
J3473	No	No	No	No	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No
J3485	No	No	No	003	No	No	No
J3489	No	No	174.0- 174.9 198.5 203.00 203.02 203.10 203.12 203.80 203.82 275.42 731.0 733.00- 733.09 OR 733.90	No	No	No	No
			700.00				

NOTE: Requires a paper claim form with the name of the drug, dosage and the route of administration for consideration for eligible beneficiaries. Clinical documentation may be required. See Section 252.111 for additional billing information.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3490	U9	16v & up	V23.41	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

J3520	No	No	No	003	No	No	No
J7178	No	No	286.3	No	No	No	No
J7180	No	2y & up	286.3	No	No	No	No
J7183	No	No	286.4	No	No	No	No
J7185	No	21y - 65y	No	No	No	No	No
J7186	No	No	No	No	No	No	No
J7187	No	No	No	No	No	No	No
J7189	No	No	No	No	No	No	No
J7190	No	No	No	No	No	No	No
J7191	No	No	No	No	No	No	No
J7192	No	No	No	No	No	No	No
J7193	No	No	No	No	No	No	No
J7194	No	No	No	No	No	No	No
J7195	No	No	No	No	No	No	No
J7196	No	18y & up	286.52- 286.59	No	No	No	No
J7197	No	No	No	No	No	No	No
J7198	No	No	No	No	No	No	No
J7199*	No	No	No	No	No	No	No

NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration. See Section 252.111 for billing instructions.

| J7300 | No | |
|-------|----|----|----|----|----|----|----|--|
| J7301 | No | |

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7302	No	No	617.0- 617.9 627.2 627.8 OR	No	No	No	No

NOTE: Covered for therapeutic use and treatment of heavy menstrual bleeding in women who have had a child or who have been pregnant.

J7303	No	No	No	No	No	No	No
J7306	No	No	No	No	No	No	No
J7307	No	No	No	No	No	No	No
J7308	No	No	No	003	No	No	No
J7310	No	No	No	003	No	No	No
J7311*	No	No	No	No	Yes	No	No
J7312*	No	18y &up	362.20 362.30 362.35 362.36 363.20	No	Yes	No	Yes

NOTE: Procedure code J7312 is covered for the allowable valid ICD-9-CM diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method. 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.

J7316* No 18y & up 379.27 No Yes No Yes

NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

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 **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. 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, 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. Refer to Section 245.031 for Prior Authorization.

J7330	No	No	No	No	No	Yes	No
NOTE:			equires prior au ation on obtainir				See Section
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No .
J7508	No	No	V42.0- V42.89	No	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
J7513	No	No	No	003	No	No	No
J7515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7520	No	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No	No
	For considerat of the drug, do				d on a pape	er claim for	m with the name
J7527	No	18y & up	V42.0	No	No	No	No
J7599*	No	No	No	No	No	No	No
	For considerat of the drug, do instructions.						m with the name billing
J8530	No	No	No	003	No	No	No
J8650	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
J9000	No	No	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No
J9017	No	No	No	003	No	No	No
J9019*	No	2y-18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	205.00- 205.92	No	No	No	Yes
			238.71- 238.76 or		`		
			238.79				
J9027	No	1y to 20y	204.00 or 204.01	No	No	No	No
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	200.30- 200.48	No	Yes	No	Yes
			202.00- 202.08				
			203.00				
			203.10				
			203.80				
			204.10- 204.12 or 238.6				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9035*	No	No	153.0- 154.8	No	Yes	No	Yes
			162.0- 162.9				
			174.0- 175.9 or				
			189.0- 189.9				
J9040	No	No	No	003	No	No	No
J9041*	No	No	203.00- 203.82	No	Yes	No	Yes
			200.40- 200.48				
J9042*	No	18y & up	200.60- 200.68,	No	Yes	No	Yes
			201.00- 201.98				

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, ICD-9-CM diagnosis 200.6 after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043* No 18y & up 185.0 No Yes No Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9047*	No	18y & up	203.00-	No	Yes	No	Yes

NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.

J9050	No	No	No	003	No	No	No
J9055*	No	No	140.0- 149.9	No	Yes	No	Yes
		•	153.0- 154.8				
			160.0- 161.9				
			171.0				
			172.0- 172.4				
			173.00- 173.49		31/		
			OR				
			195.0				
J9060	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9098	No	No	No	003	Yes	No	No
J9100	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9155	No	21y & up	No	003	No	No	No
NOTE: C	Covered for	male beneficiar	ies only.				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9160	No	No	201.10- 202.18	No	Yes	No	Yes
			202.20- 202.28				
			OR				
			202.80- 202.88				
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	150.0- 150.8 151.0-	003	Yes	No	Yes
		,	151.0				
			162.0- 162.9				
			171.0- 171.9				
			174.0- 175.9	U			
			183.0	V			
			200.00- 200.88				
			Or				
			202.00- 202.98				
J9179*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

No	No	No	003	No	No	No
Nie						
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
_	No					

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	174.0- 175.9	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	185 198.82 or V10.46	No	No	No	No

NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.

J9225	No	No	185	No	No	No	No	
J9226*	No	0-12y	259.1	No	Yes	No	Yes	

NOTE: Supprelin LA: Prior to initiation of treatment, a clinical diagnosis of CPP, ICD-9-CM code 259.1, should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor) and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with history and physical examination when requesting prior approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9228*	No	18y & up	172.0- 172.9	No	Yes	No	Yes

NOTE: **Ipilimumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for **Zelboraf**. If positive for the mutation, the patient should first be given a trial of **Zelboraf**. If the patient fails the trial or does not have the mutation, then they should be considered for **Ipilimumab**. **Ipilimumab** should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of **Ipilimumab** requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with **Ipilimumab** should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	202.80- 202.88 or	No	Yes	No	Yes
			204.00- 208.92				

NOTE: The disease must have not responded to, or either has relapsed, following treatment with at least 2 chemotherapy regimens.

J9262*	No	18y & up	205.10-	No	Yes	No	No
		, ,	205 12				

NOTE: **Synribo** is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.

J9263*	No	No	151.0- 151.9	No	Yes	No	Yes
			153.0- 154.8				
			183.0- 183.9 and				
			202.00- 202.98				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9264*	No	No	140.0- 149.9	No	Yes	No	Yes
			154.2- 154.3				
			157.0- 157.3				
			157.8				
			157.9				
	•		158.8				
			160.0- 162.9				
			174.0- 175.9				
			183.0- 183.9	3			
			195.0				
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No
J9293	No	No	Yes	No	Yes	No	No
NOTE: F	Requires ICD-	9-CM diagnosi	s code for ca	ncer or ICD-9	9-CM diagno	osis code o	of 340.
J9300	No	No	No	003	No	No	No
J9303*	No	No	153.0- 154.8	No	Yes	No	Yes
J9305*	No	No	162.0- 163.9	No	Yes	No	Yes
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Perjeta** is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with tratuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.

J9307	No	18y & up	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9310	No	No	No	003	No	No	No
J9315	No	18y & up	No	003	No	No	No
J9320	No	No	No	003	No	No	No
J9328*	No	21y & up	191.0- 191.9	No	Yes	No	Yes

NOTE: The diagnosis must be for:

Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	189.0- 189.1	No	No	No	No
J9340	No	No	No	003	No	No	No
J9351	No	18y & up	No	003	No	No	No
J9354*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **traztuzumab** and a **taxane**, separately or in combination. Patients should have either:

1. received prior therapy for metastatic disease,

OR

developed disease recurrence during or within six months of completing adjuvant therapy.

All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.

J9355	No	No	No	003	No	No	No
J9357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9371*	No	18y & up	204.00- 204.02	No	Yes	No	Yes
NOTE:	chromosome whose diseas history and ph	vinca alkaloid ir negative (Ph-) a e has progresso nysical exam do be on a case-by	acute lympho ed following t cumenting a	blastic leuke wo or more a	mia in seco anti-leukemi	nd or great c therapies	er relapse or . A complete
J9390	No	No	No	003	No	No	No
J9395*	No	No	174.0- 175.9	No	Yes	No	Yes
J9400*	No	18y & up	153.0- 154.8	No	Yes	No	Yes
NOTE:	(mCRC), that complete histo	re code is indicate is resistant to open and physicate en on should be	r has progres I exam docur	sed following	g an oxalipla	atin-contair	ning regimen.
J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No
NOTE:	See Section 2	252.111 in this n	nanual for co	verage inform	nation.		
P9012*	No	No	No	No	No	No	No
NOTE:	Attach the ma	nufacturer's inv	oice to the cl	aim. See Se	ection 272.4	43 for addit	tional
ITOTE.	information.						
P9041		No	No	No	No	No	No
	information.	No No	No No	No No	No No	No	No No
P9041 P9045	information.						
P9041 P9045 P9046	No No	No	No	No	No	No	No
P9041	No No No	No No	No No	No No	No No	No No	No No
P9041 P9045 P9046 P9047 Q0139	No No No No No No	No No No	No No No 584.5-	No No No	No No No	No No	No No No
P9041 P9045 P9046 P9047 Q0139	No	No No No	No No No 584.5- 586.0	No No No No	No No No No	No No No No	No No No No
P9041 P9045 P9046 P9047 Q0139	No	No No No No 4y & up	No No No 584.5- 586.0	No No No No	No No No No	No No No No	No No No No
P9041 P9045 P9046 P9047 Q0139 Q0162 NOTE: Q0166	Information. No No No No No UB Q0162-UB republic	No No No Ay & up presents "Onda No ier for Q0166 —	No No S84.5- 586.0 No nsetron 1 mg	No No No No oral" billable	No No No No No No No No No Relectronica	No No No No ally or on p	No Apper.
P9041 P9045 P9046 P9047 Q0139 Q0162 NOTE: Q0166	Information. No No No No No UB Q0162-UB rep UB Use UB modif	No No No Ay & up presents "Onda No ier for Q0166 —	No No S84.5- 586.0 No nsetron 1 mg	No No No No oral" billable	No No No No No No No No No Relectronica	No No No No ally or on p	No Apper.
P9041 P9045 P9046 P9047 Q0139 Q0162 NOTE: Q0166 NOTE:	Information. No No No No No UB Q0162-UB rep UB Use UB modif Medicaid desc	No No No No 4y & up presents "Onda No ier for Q0166 — cription.	No No S84.5- 586.0 No nsetron 1 mg No "Granistron F	No No No No No oral" billable 003 HCl tab 1 mg,	No No No No No e electronica No oral" (Kytri	No No No No No ally or on p No ii). This is	No No No No No No aper. No the Arkansas

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

Prior

PA

Review

See Section 241.000 for prior authorization procedures.

Modifier

Procedure

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

Age

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Diagnosis

Diagnosis

Code		Restriction	Diagnosis	List			Approval Letter
Q2043*	No	18y & up	185	No	Yes	No	Yes
NOTE:	castrate resis two-week inte treatment and radiology stud Concomitant been studied	ndicated for the stant (hormone is ervals will be ap didocumentation dies showing spuse of chemoth. This drug will so A detailed metalled metalled metalled metalled metalled metalled metalled.	refractory) pro proved. The n of no respon pread or some nerapy or imm only be appro	ostate cancer re must be clause by Prostate to other methon nunosuppress	Only three ear docume ate Specific of of determants sive medicaters that have	e doses add entation of u Antigen levalining metas tion with this e the ability	ministered at use of hormone rels, abnormal static disease. Is drug has not to perform
Q2049	No	18y & up	No	003	No	No	No
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4081	No	No	584.5- 586	No	No	No	No
Q4101	No	No	No	No	No	No	No ·
Q4102	No	No	No	No	No	No	No
Q4103	No	No	No	No	No	No	No
Q4104	No	No	No	No	No	No	No
Q4105	No	No	No	No	No	No	No
Q4106	No	No	No	No	No	No	No
Q4107	No	No	No	No	No	No	No
Q4108	No	No	No	No	No	No	No
Q4110	No	No	No	No	No	No	No
Q4111	No	No	No	No	No	No	No
Q4112	No	No	No	No	Yes	No	No
Q4113	No	No	No	No	Yes	No	No
Q4114	No	No	No	No	Yes	No	No
Q4116	No	No	174.0- 175.9	No	No	No	No
Q4121	No	No	No	No	No	No	No
Q4124	No	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No	No
NOTE:	Attach the ma	anufacturer's inv	voice to the c	laim.			
Q4145*	No	No	No	No	No	No	No
NOTE:	Attach the ma	anufacturer's inv	voice to the c	laim.			

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol).

See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q9969	No	No	No	No	No	No	No
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
S0032	No	No	No	003	No	No	No
S0034	No	No	No	003	No	No	No
S0039	No	No	No	003	No	No	No
S0040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
S0077	No	No	No	003	No	No	No
S0078	No	No	No	003	No	Yes	No
S0080	No	No	No	003	No	No	No
S0081	No	No	No	003	No	No	No
S0092	No	No	No	003	No	No .	No
S0093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
S0119	No	4y & up	No	No	No	No	No
S0145	No	No	070.54	No	No	No	No
S0164	No	No	No	003	No	No	No
S0177	No	No	No	003	No	No	No
S0179	No	No	No	003	No	No	No
S0187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No
NOTE: I	Procedure cod	e Z1847 is for	Torecan 10 r	ng oral tablet	ts. Limit of	(4) 10 mg ta	abs per day.
90375*	No	No	No	No	No	No	No
ć	Each date of so along with the anatomical site administration	clinical administ and route of a	stration recor	ds indicating	medical ne	cessity, dos	sage,

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC protocol). See Section 241.000 for prior authorization procedures.

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedo Code	ure Modifie	r Age Restriction	° Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90376*	No	No	No	No	No	No	No
NOTE:	along with the	service must be e clinical adminis ite and route of a n fee.	stration recor	ds indicating	medical ne	cessity, dos	sage,
90385	No	No	No	No	No	No	No
NOTE:	Procedure co	ode 90385 is limi	ted to one inj	jection per pr	egnancy.		
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose	and attach the	m anu facture	r's invoice to	the claim.		
90632	No	19y & up	No	No	No	No	No
90662	No	65y & up	No	No	No	No	No
NOTE:		ode 90662 is cov after October 1		eficiaries age	s 65 years	and older fo	or dates of
90673	No	19y-49y	No	No	No	No	No
90675*	No	No	No	No	No	No	No
NOTE:	paper claims date of service must be iden	ode 90675 is cov with procedure ce. If date spans tified for each da oursement rate is	code and dos are used, ap ate within the	sage entered opropriate un span. Attack	in claim for its of service the manul	m CMS-14 e must be i	50 for each indicated and
90676*	No	No	No	No	No	No	No
NOTE:	paper claims date of service must be iden	ode 90676 is cov with procedure ce. If date spans tified for each da oursement rate in	code and dos are used, ap ate within the	sage entered opropriate un span. Attach	in claim for its of servic the manul	m CMS-14 e must be i	50 for each indicated and
90690	No	6y & up	No	No	No	No	No
90691	No	3y & up	No	No	No	No	No
90703	No	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No	No
			Ma	MI-	Ale	A.L.	* 1
90705	No	1y & up	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC

See Section 272.103 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include: 042, 140.0-209.36, 209.70-209.75, 209.79, 230.0-238.9, 511.81 or V58.11-V58.12. Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90707	U1	21y – 44y	No	No	No	No	No
th	rough 44, wh	le 90707 is pay no may be at ris ifetime. U1 mo	sk of exposui	re to these di	seases. Co		ge, ages 21 imited to two (2
90707	No	19y – 20y	No	No	No	No	No
90708	No	9m & up	No	No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: A	ttach the mar	nufacturer's inv	oice to the c	aim.			
90732	No	2y & up	No	No	No	No	No
		1 years and old th risk. All ben					
90733	No	No	No	No	No	No	No
90735	No	0 – 20y	No	No	No	No	No
90736	No	60y & up	No	No	No	No	No
NOTE: Zo	ster vaccine is	s benefit limited	to once in a l	ifetime.			
90740	No	No	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
96379*	No	No	No	No	No	No	No
p	rovided (drug	r procedure co , dose, route o uding documer	f administrati	on) as well a	s clinical no		n of the service ing the

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.102 for NDC



Division of Medical Services

Program Development & Quality Assurance

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TO:

Arkansas Medicaid Health Care Providers - Federally Qualified Health

Center

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal FQHC-2-15

REMOVE Section

Date _

Section 262,441

Date 10-1-15

262.442

10-1-15

Explanation of Updates

Section 262.441 is added to include National Drug Code (NDC) information.

Section 262.442 is added to include current drug vial policy.

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.

Dawn Stehle Top

Director

TOC required

262.441 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LACELER	LABELER NAME	EN EANVE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	And Additional to the second
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

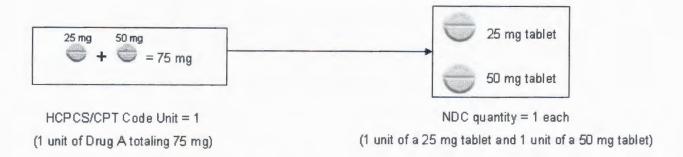
II. Claims Filing

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

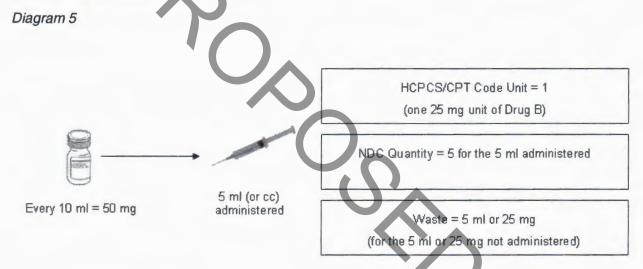
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	WW	Pican	XX	1414	20	44	PLACE OF		. 0	SESPHANTO PEROPOS	nyasawi O	orcagonajasj falk	Model WHEE		POINT		\$ CHARPOLES	SICIS UNIS	Hagenby Diggs	IQ. OLME.	PROVIDER ID. #
Journal 1	N4	1234	6671	912	UN	1.00							,								123456789
Sequence 2	80	01	07	08	01	07	111		2	11234			1		14		25 00	1		1484	
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Detail 3									6		8						1			NPI	ectuar opo sarrer esc toc saccion oso est per or

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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

262.442 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - Multi-Use Vials are not subject to payment for any discarded amounts of the drug.
 The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. **Paper Billing:** 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 262.441 for additional information regarding National Drug Code (NDC) billing.

MARK-UP

TOC required

262.441 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER		YER EN WIE	TERMINETRON
PEUDE	A LASE ER HAME A LASE AND A LASE	DATE	DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	123456789 0 1
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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

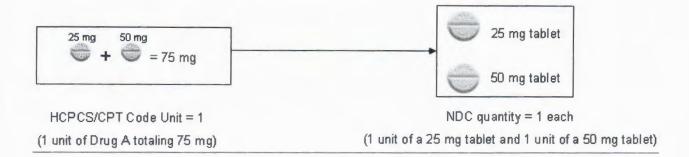
II. Claims Filing

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

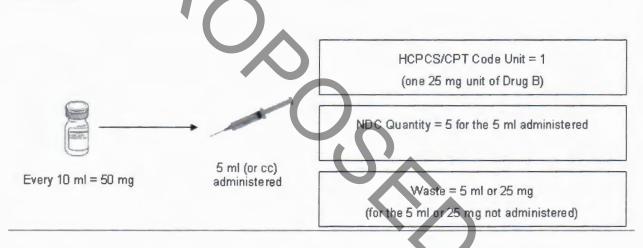
example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If 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. See Diagram 5.





A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	3468	200	XX	1610	50	44	PLACES		0 0	(Explore () FT3+CPCS	YSUAD CASE		MANUEL COMPRES	N.	(XIAGINI PICIPI		1 CHAPGE	8	CHESS.	Figure Sign	CRP4E	RENDSAING PROVIDER ID. #
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Sequence 2	08	01	07	08	01	07	111		1 2	1234		ì			1	-	25	00	4		34874	
	N4	0111	11222	233	UN	1.00			_													123466789
-	08	01	02	03	01	07	111	***************************************	1 2	1234		0.00	Action of		1	Messer	0	00	0	-	16F1	
Detail 2)			-	1																	123466789
	08	01	07	80	01	07	111		1	20213	No.	-	St.	-	1	2000	55	00	1		1691	
	N4	ALC:	44555	506	ML	40c	w/80000009-0000		000000000000		11 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Lavado (Britishi)	ucacomor.	engeedbys/222	100 - 1000 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 1	00x = UCC0000 WCU	000.00000000000000000000000000000000000	***********	No consideration of the	cerepouvrene		123455789
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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

3 4 5 6	7 8 9 1 2	Z1234	ABC drug/25 MG/Oral	0
1 1 1 2	2 2 2 3 3	Z1234	XYZ drug/50 MG/Oral	0
4 4 4 5	5 5 5 0 6	Z6789	PRQ drug/5 ML/IV	5 ML
	1 1 1 2 4 4 5	1 1 1 2 2 2 2 3 3 4 4 4 5 5 5 5 0 6	1 1 1 2 2 2 2 3 3 21234	1 1 1 2 2 2 2 3 3 Z1234 XYZ drug/50 MG/Oral

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

262.442 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 262.441 for additional information regarding National Drug Code (NDC) billing.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Home Health

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal HOMEHLTH-3-15

REMOVE		INSERT	
Section	Date	Section	Date
		242.143	10-1-15
_		242.144	10-1-15

Explanation of Updates

Section 242.143 is added to include National Drug Code (NDC) information.

Section 242.144 is added to include current drug vial policy.

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.

Stulleton

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle Director TOC required

242.143 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. 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.

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

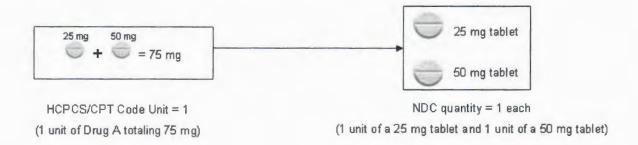
HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that 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

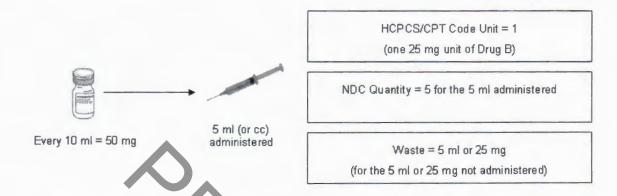
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 3.



Example 2: If 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)

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.

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 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.

		40 MBH CS.	45 pagonerson	44 HCPCS (\$200) HPF\$ 0005	ot offer; cust	AN ENDINE LANGES	defector (markets	HE MON-COVERNO CHARGES	-
	Sequence 1	0636	N4 12345678912 UN 1 00	Z1234	08/01/07	1	2500	**************************************	- Contract of the Contract of
	Sequence 2	0536	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00	100000000000000000000000000000000000000	annound dec
Detail 2		0305	Hemogram	85025	08/01/07	1	55 00	96000000	************
	Sequence 1	0636	N4 44444555506 UN 5.00	26789	08/01/07	1	2100	64.00000	*******

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. <u>View or print form DMS-664 and instructions for completion</u>.

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.

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.

242.144 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - 1. Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas

Medicaid will cover the amount of the drug discarded along with the amount administered.

- Multi-Use Vials are not subject to payment for any discarded amounts of the drug. 2. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
- **Documentation:** The provider must clearly document in the patient's medical record 3. the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
- 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 242.143 for additional information regarding National Drug Code (NDC) billing.



MARK- UP

TOC required

242.143 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. 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 HCPOS/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.

00123	0456	<u>78</u>
LABELER CODE	PRODUCT CODE	PACKAGE CODE
(5 digits)	(4 digits)	(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

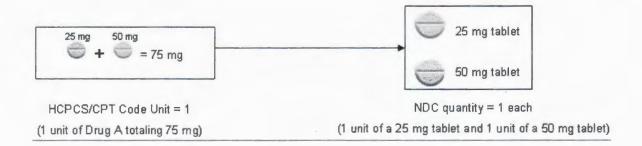
PCCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the 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

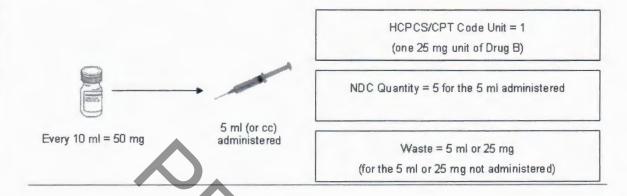
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 3.



Example 2: If 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 837/ (Outpatient)

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.

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 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.

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	Sequence 2	0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00	*	WWW.
Detail 2		0305	Hemogram	85025	08/01/07	1	55:00	0	Annual An
	Sequence 1	0636	NA 44444555506 UN 5.00	Z6789	08/01/07	1	2100	oeeen.	NAME OF THE PARTY

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.

Diagram 6

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

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.

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.

242.144 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas

- Medicaid will cover the amount of the drug discarded along with the amount administered.
- 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
- 3. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
- 4. Paper Billing: 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.
- Remember to verify the milligrams given to the patient and then convert to the proper units for billing.
- Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 242.143 for additional information regarding National Drug Code (NDC) billing.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Hyperalimentation

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal HYPER-2-15

REMOVE		INSERT	
Section	Date	Section	Date
_		242.401	10-1-15
_		242.402	10-1-15

Explanation of Updates

Section 242.401 is added to include National Drug Code (NDC) information.

Section 242.402 is added to include current drug vial policy.

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.

Days Steple Total
Dawn Stehle
Director

TOC required

242.401 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellancx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	123456789 0 1
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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

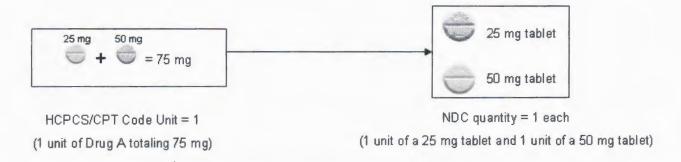
II. Claims Filing

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

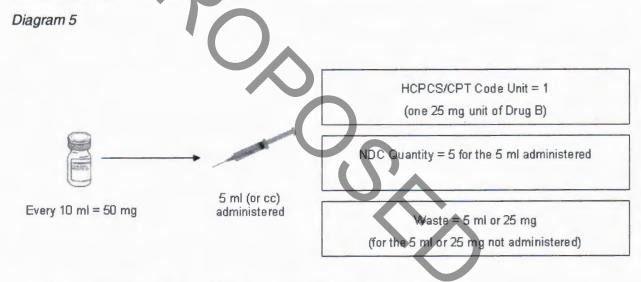
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 2 08 01 07 08 01 07 11	23455789
Detail 2 2 N4 01111222233 UN 1.00	
Detail 2 N4 01111222283 UN 1.08 08 01 07 08 01 07 11	
Detail 2 3 08 31 07 08 01 07 11 99213 1 1 55 00 1 N4 44466308 4 30	23456789
08 41 07 08 01 07 11 99213 1 1 55 00 1 MAI	
N4 444000000000000000000000000000000000	23466789
NA STAGROOSEE M. AUC	
	23466799
Sequence 1 4 08 01 07 08 01 07 11 20789 1 35 00 1 1	to the second of the second of the
Detail 3 5	-

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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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	11	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

242.402 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

TOC required

242.401 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER CODE	LABELER NAME	DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	11110
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	No. VVII II MARKET MARK
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

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

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

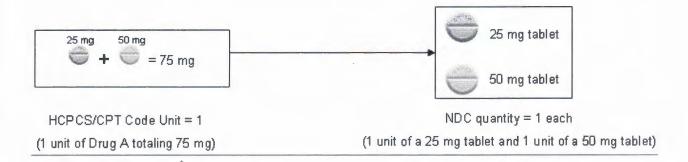
II. Claims Filing

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

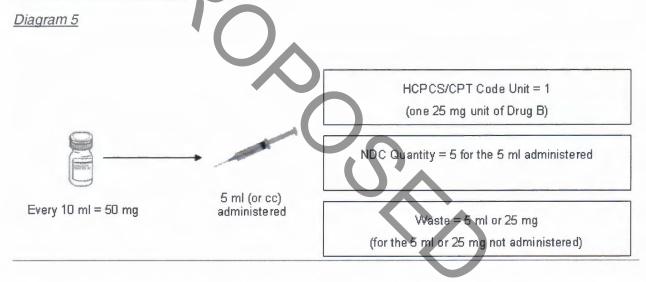
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one

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 4



Example 2: If 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. See Diagram 5.



- A. Electronic Claims Filing 837P (Professional) and 837I (Outpatient)
- 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 requires providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.
- B. Paper Claims Filing CMS-1500
- Arkansas Medicaid will require providers billing drug HCPCS/CPT codes including covered unlisted drug procedure codes to use the required NDC format.
 - See Diagram 6 for CMS-1500.
- For professional claims, CMS-1500, list the qualifier of "N4," the 11-digit NDC, the unit of measure qualifier (F2 International Unit; GR Gram; ML Milliliter; UN Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	\$4. d	Form	THE REST OF	UN DE	**	PLACE SUPAR		MG.	SENSINGS CPTHICPCS		PPschCdEss Consumblesh Bd			DIVIDA		# CHARGES	-		IQ. Glavis.	PROVIDER ID: #
L	2.0	4	66789				1	0446	77.45-0-4		1	3	ŧ	1.4	1	04.1	mo i	4	es: 10.	12:3466789
Sequence 2	Someone	01	12222	Marian direction		111			Z1234							25 (00		 461	123466789
	2 08	01		8 01	07	111		Young	Z1234	000000	3 4.	*	Tauton 1	11	900000	ole	00	0	NPS	123700700
Detail 2	3			:		and the same and	nadio	2				A. A. COMPANIES CO.				eco-menteration continuation	eisvinah.co.			123466789
	~ 08	04	07 0	8 01	97	111			90213					11		55 (20	1	945	
Sequence 1	4 N4	01	07 0	8 01	07	111			ZB789	11	1	1	1	11		35	00	4	3454	123456789
Detail 3	5	According	Bage annualing		ar opposite to	and the same	,	t-corregion 5	NAME OF THE PERSON OF THE PERS	enter Patricia		-	1	officeren .		errore en	www.k	uiv minmodi	 	

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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

#	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

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

242.402 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.



Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Physician/Independent

Lab/CRNA/Radiation Therapy Center

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal PHYSICN-4-15

REMOVE		INSERT	
Section	Date	Section	Date
292.910	11-1-08	292.910	10-1-15
292.950	2-15-15	292.950	10-1-15

Explanation of Updates

Section 292.910 is updated to include current National Drug Code (NDC) information.

Section 292.950 is updated to include current drug vial policy.

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.

Day Stehle Fall

Director

TOC not required

292.910 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	Haba one

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 2 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 2

	00123	0456	78
1	LABELER	PRODUCT	PACKAGE
1	CODE	CODE	CODE
	(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	123456789 0 1
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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

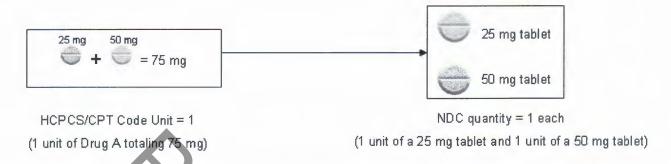
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

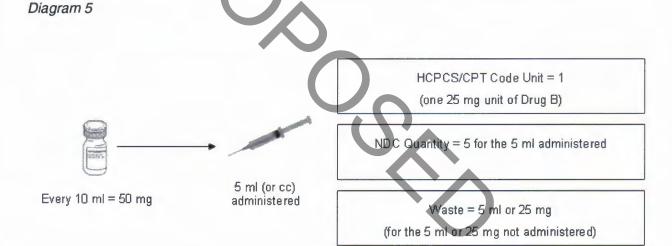
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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 yial, 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. See Diagram 5.



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

123466769
123456789
123455789
123466789
123466789

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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

7						NDC						Proc Code /Modifier	Drug Name/Dose/Route	Wasted
1	1	2	3	4	5	6	7	8	9	1	2	Z1234	ABC drug/25 MG/Oral	0
2	0	1	1	1	1	2	2	2	2	3	3	Z1234	XYZ drug/50 MG/Oral	0
1	4	4	4	4	4	5	5	5	5	0	6	Z6789	PRQ drug/5 ML/IV	5 ML
-	1 2 1	1 1 2 0 1 4	1 1 2 2 0 1 1 4 4	1 1 2 3 2 0 1 1 1 4 4 4	1 1 2 3 4 2 0 1 1 1 1 4 4 4 4	1 1 2 3 4 5 2 0 1 1 1 1 1 4 4 4 4 4	1 1 2 3 4 5 6 2 0 1 1 1 1 2 1 4 4 4 4 4 5	1 1 2 3 4 5 6 7 2 0 1 1 1 1 2 2 1 4 4 4 4 4 5 5					2 0 1 1 1 1 2 2 2 3 3 3 21234	2 0 1 1 1 2 2 2 2 3 3 Z1234 XYZ drug/50 MG/Oral

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 292.950 for additional information regarding drug code billing.

292.950 Injections, Therapeutic and/or Diagnostic Agents

10-1-15

A. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code, T1502 is payable for beneficiaries of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "ORALLY." No fee is billable for drugs administered orally.

T1502 cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

T1502 cannot be billed to administer any medication given for family planning purposes. No other fee is billable when the provider decides not to supply family planning injectable medications.

T1502 cannot be billed when the drug administered is not FDA approved.

See the table below when billing T1502:

Procedure Code	Modifier	Eligibility Category
T1502	EP	ARKids-A (Ages 0-20)
T1502		ARKids-B
T1502	•	Ages 19 and above

Most of the covered drugs can be billed electronically. However, any covered drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column, Field 24D, of the CMS-1500 claim form. View a CMS-1500 sample form. If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

See Section 292.940 for coverage information of radiopharmaceutical procedure codes.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 292.910 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by

physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379 and 96401 through 96549 for therapeutic and chemotherapy administration procedure codes.

See Section 292.940 for radiopharmaceutical drugs.

- B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:
 - 1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
 - 2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
 - 3. All other billing requirements must be met in order for payment to be approved.

C. Immunizations

Physicians may bill for immunization procedures on the CMS-1500 claim form. <u>View a</u> CMS-1500 sample form. See Section 292.950 for covered vaccines and billing protocols.

Coverage criteria for all immunizations and vaccines are listed in Part E of this section.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and obviously which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. Vaccines for Children (VFC)

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. View or print Arkansas Division of Health contact information.

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**. When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **TJ** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables section of this manual. See Part F of this section.

E. Billing of Multi-Use and Single-Use Vials

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- 1. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - a. Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - b. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - c. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - d. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 292.910 for additional information regarding National Drug Code (NDC) billing.

F. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- 1. The **first** column of the list contains the CPT or HCPCS procedure codes.
- 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(y) or months (m).
- 4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
- 5. The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
- The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)
- 8. The <u>eighth</u> 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. <u>View contact information for the Medical Director for Clinical Affairs</u> for the Division of Medical Services.

No

No

C9257*

C9286

21y & up

18y & up

Yes

NOTE: Coverage of procedure code C9257 is for ages 21 years and above with any of these

View ICD

Codes.

would contraindicate the use of Avastin, and documentation of patient consent.

No

diagnosis codes (View ICD Codes.). Documentation included with Prior Approval Letter request must include Fluoroscein angiogram or OCT, patient screen for conditions that

No

Procedu Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0- 175.9	No	No	No	No
A9575	No	2y & up	No	No	No	No	No
A9580*	No	No	View ICD Codes.	No	No	No	No
		e A9580 is pay uires a paper c euticals.					
AOFOF							
A9585	No	2y & up	No	No	No	No	No
	No	2y & up	View ICD Codes.	No	No No	No No	No No
A9585 A9586 C9132			View ICD				
A9586 C9132 NOTE:	No Kcentra is indictly Vitamin K a Kcentra is not major bleeding and physical e	18y & up 18y & up cated for the untagonist (VKZ indicated for unitage). Documentation and the cam. All treatrant hemoglobin and the came of the came	View ICD Codes. 286.7 Irgent reversation of the mannents needed	No No al of acquired in) therapy in al of VKA ant jor bleed sho	Yes I coagulatio adult patie icoagulatior ould be inclu or bleed pric	No No n factor defents with major in patients add in a coor to Kcentr	No No iciency induce for bleeding. without acute mplete histor a should be
A9586 C9132 NOTE:	No Kcentra is indicated by Vitamin K a Kcentra is not major bleeding and physical edocumented.	18y & up 18y & up cated for the untagonist (VKZ indicated for unitage). Documentation and the cam. All treatrant hemoglobin and the came of the came	View ICD Codes. 286.7 Irgent reversation of the mannents needed	No No al of acquired in) therapy in al of VKA ant jor bleed sho	Yes I coagulatio adult patie icoagulatior ould be inclu or bleed pric	No No n factor defents with major in patients add in a coor to Kcentr	No No iciency induce for bleeding. without acute mplete histor a should be
A9586 C9132 NOTE:	No Kcentra is indictly Vitamin K a Kcentra is not major bleeding and physical educumented. As the dose of was	18y & up 18y & up cated for the untagonist (VKZ indicated for unitage). Documentation and the model of the	View ICD Codes. 286.7 Irgent reversation of the manents needed and hematoc	No No al of acquired n) therapy in al of VKA ant jor bleed sho d for the major rit should be	Yes I coagulatio adult patie icoagulatior ould be inclu or bleed prio documente	No No n factor defents with major in patients added in a coor to Kcentr d in the reco	No No iciency induce jor bleeding. without acute mplete histor a should be ord as well as
A9586 C9132 NOTE:	No Kcentra is indictly Vitamin K a Kcentra is not major bleeding and physical explorations of the dose of wa No	18y & up 18y & up cated for the untagonist (VKZ indicated for unitagonist (VKZ indicated for unitagonist (VKZ indicated for unitagonist (VKZ indicated for unitagonist). A hemoglobin arfarin.	View ICD Codes. 286.7 Irgent reversation of the mainents needed and hematocode.	No No No al of acquired in) therapy in al of VKA ant jor bleed sho d for the major rit should be	No Yes I coagulation adult patienticoagulation ould be included by the company of the company o	No No n factor defents with major in patients uded in a coor to Kcentr d in the rec	No No iciency induction bleeding. without acute implete historia should be ord as well as

No

No

No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9287*	No	18y & up	View ICD	No	Yes	No	Yes

NOTE: This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multiagent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. Prior approval letter requests should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. The discussion of risk of PML should be documented in medical records.

C9363	No	No	View ICD Codes.	No	No	No	No	
C9441	No	18y & up	280.0- 280.9	No	No	No	No	
			and					
			285.1		\'\			
			or					
			585.1-					
			585.9					

NOTE: Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

J0120	No	No	No	003	No	No	No	
J0129*	No	No	View ICD	No	No	No	Yes	

NOTE: Patient must have had inadequate response to one or more disease-modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam
showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic
drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis,
etc.

J0133	No	No	View ICD	No	No	No	No	
			Codes.					

See Sections 261.000 - 261.220 for prior authorization procedures.

Affairs for a Prior Approval letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0150	No	No	No	No	No	No	No
NOTE: Ma	ximum units	s allowed are 4	per day.				
J0151	No	No	No	No	No	No	No
J0171	No	No	No	No	No	No	No
J0178*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction of vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical

J0180* No No <u>View ICD</u> No No Yes Codes.

NOTE: Procedure code J0180 is covered for treatment of Fabry's disease, with an ICD diagnosis code of (View ICD Codes.).

J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	No	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: Evaluation by a physician with a specialty in clinical genetics documenting progress required annually.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0221*	No	No	271.0	No	Yes	No	Yes

NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile, Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme 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 FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.

J0256	No	No	View ICD Codes.	No	No	No	No	
J0257	No	18y & up	View ICD Codes.	No	No	No	No	

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable. clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha 1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No
J0280	No	No	No	003	No	No	No
J0285	No	No	No	003	No	No	No
J0287	No	No	No	003	No	No	No
J0288	No	No	No	003	No	No	No
J0289	No	No	No	003	No	No	No
J0290	No	No	No	003	No	No	No
J0295	No	No	No	003	No	No	. No
J0300	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0330	No	No	No	003	No	No	No
J0348	No	No	Yes	003	No	No	No
(Vi	ew ICD Cod	e J0348 is vali des.): (1) End- us or specify tr	stage Renal I	Disease or (2	AIDS or C	Cancer or (
(Vi	ew ICD Cod	des.): (1) End-	stage Renal I	Disease or (2	AIDS or C	Cancer or (
(<u>Vic</u> trar	ew ICD Coonsplant state	des.): (1) End- us or specify tr	stage Renal I ansplanted o	Disease or (2 rgan and trai	2) AIDS or Consplant date	Cancer or (3) Post

J0360	No	Nø	No	003	No	No	No
J0380	No	No	No	003	No	No	No
J0390	No	No	No	003	No	No	No
J0401	No	13y & up	295.00- 295.95	No	No	No	No
J0456	No	No	No	003	No	No	No
J0461	No	No	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	View ICD Codes.	No	No	No	No
J0485	No	18y & up	View ICD Codes.	No	No	No	No
J0490	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.

J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is revi	ewed for medic	cal necessity	based on IC	D diagnosis	code.	
J0586	No	No	No	No	Yes	No	No
NOTE:	This procedure billed.	e code is review	ved for medic	cal necessity	based on a	n ICD diag	nosis code
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD diagno	sis code which	supports me	edical necess	sity is requir	red.	
J0592	No	No	No	003	No	No	No
J0595	No	No	No	003	No	No	No
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
J0630	No	No	No	003	No	No	No
J0636	No	No	View ICD Codes.	No	No	No	No
J0637*	No	No	No	No 🐧	Yes	No	No

NOTE: Procedure code J0637 is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage. After 30 days of use, an updated medical exam and history must be submitted.

J0638	No	4y &up	View ICD Codes.	No	No	No	No
J0640	No	No	No	003	No	No	No
J0641*	No	No	View ICD Codes.	No	Yes	No	Yes

NOTE: Approved Only:

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

J0670	No	No	No	003	No	No	No
J0690	No	No	No	003	No	No	No
J0692	No	No	No	003	No	No	No
J0694	No	No	No	003	No	No	No
J0696	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (<u>View ICD Codes.</u>). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0697	No	No	No	003	No	No	No
J0698	No	No	No	003	No	No	No
J0702	No	No	Yes	003	No	No	No
		e J0702 is cov of pregnancy o			code (View	ICD Code	es.)for
J0706	No	No	No	003	No	No	No
J0710	No	No	No	003	No	No	No
J0712	No	18y & up	No	No	No	No	No
J0713	No	No	No	003	No	No	No
J0715	No	No	No	003	No	No	No
J0716	No	No	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Sections 261,000 - 261,220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0717*	No	18y & up	555.0- 555.9 or 714.0	No	Yes	No	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (Cimzia) 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 corticosteroids or 6-mercaptopurine/azathioprine.

or

For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed Enbrel and Humira.

J0720	No	No	No	003	No	No	No
J0725	No	No	No	003	No	No	No
J0735	No	No	No	003	No	No	No
J0740	No	No	No	003	No	No	No
J0743	No	No	No	003	No	No	No
J0744	No	No	No	003	No	No	No
J0745	No	No	No	003	No	No	No
J0760	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0770	No	No	No	003	No	No	No
J0780	No	No	No	003	No	No	No
J0795	No	No	No	003	No	No	No
J0800	No	No	No	003	No	No	No
J0833	No	No	No	No	No	No	No
J0834	No	No	No	No	No	No	No
J0850	No	No	No	003	No	No	No



*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881 J0885	No	No	Yes; see below	No	No	No	No

NOTE: For patients on dialysis, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

When the beneficiary is not on dialysis, use ICD-9-CM 285.21.

In addition to the primary diagnosis, an ICD diagnosis code from each column below must be billed on the claim.

Column	Column	II
	Code	Description
Secondary Anemia (View ICD codes.)	View ICD Codes.	Encounter for antineoplastic chemotherapy
	View ICD Codes.	Following chemotherapy
	View ICD Codes.	Antineoplastic and immunosuppressive drugs

Use ICD code (<u>View ICD Codes.</u>) (primary) with (<u>View ICD Codes.</u>) (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

		Column I		Column	11		
			-	Code	Description		
		Anemia of other c disease (View ICI codes.)		View ICD Codes.	Chronic Hepati mention of con		
				View ICD Codes.	Myelodysplasti	С	
				View ICD Codes.	Rheumatoid Ar	thritis	
J0882	No	No	View ICD Codes.	No	No	No	No

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0885							
NOTE: See	e procedure	code J0881 ir	this section	for specific o	riteria.		
J0886	No	No	View ICD Codes.	No	No	No	No
J0894*	No	No	View ICD Codes.	No	No	No	Yes
J0895	No	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (View ICD Codes.). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer (View ICD Codes.) or adjuvant aromatase inhibitor therapy for breast cancer (View ICD Codes.). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	٨	10y & up	٨	No	No	No	No

J1050 is covered for therapeutic and family planning services for females only. For therapeutic use, a diagnosis and clinical records must justify the treatment. When billed for family planning, a FP modifier and an ICD family planning diagnosis is required.

NOTE: Relative to post occlusion by placement of permanent implants; procedure codes J1050, 11976 and 58301 are payable family planning services for non-sterile females only. All visits related to post-58565 services during the six months following the procedure are included in the allowable fee for the 58565 "procedure." All facility fees for J1050 are bundled under the surgical procedure code if performed on the same date of service.

J1060	No	No	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code from the following range of ICD codes (View ICD Codes.) for complications of pregnancy or List 003 for all ages.

J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No
J1267	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below :

- A valid ICD diagnosis from list 003 or a valid ICD code of the following renal failure code range (View ICD Codes.).
- Plus an ICD diagnosis from the following code range (View ICD Codes.).

Plus an ICD diagnosis of (View ICD Codes.).

J1300	No	No	View ICD Codes.	No	No	No	No
J1320	No	No	No	003	No	No	No
J1325	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1442	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	View ICD Codes.	No	No	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No
J1556*	No	6y & up	279.06	No	Yes	No	Yes

NOTE: **Bivigam** is an immune globulin intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J1557	No	2y & up	No	No	Yes	No	No
NOTE:	An ICD diagno	sis code that s	upports med	ical necessity	is required	d.	
J1559	No	4y & up	View ICD Codes.	No	No	No	No
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diag	nosis code	billed.
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	cal necessity	based on th	e ICD diag	nosis code	billed.
J1568	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	cal necessity	based on th	e ICD diag	nosis code	billed.
J1569	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for medi	cal necessity	based on th	e ICD diag	nosis code	billed.
J1570	No	No	No	003	No	No	No
J1580	No	No	No	003	No	No	No
J1590	No	No	No	003	No	No	No
J1599	No	4y & up	No	No	Yes	No	No
NOTE: (Claims are rev	iewed for medi	cal necessity	based on th	e ICD diag	nosis code	billed.
J1600	No	No	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1602*	No	18y & up	556.0- 556.9	No	Yes	No	Yes
		696.0 714.0- 714.9	696.0				
			721.9				

NOTE: Simponi is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- 1. Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 2. Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 3. Active ankylosing spondylitis that has failed Humira and Enbrel.
- 4. Moderate to severe ulcerative colitis that has failed Humira.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	View ICD Codes.	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No	No	003	No	No	No
J1670	No	No	No	003	No	No	No
J1700	No	No	No	003	No	No	No
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	No	16y & up	View ICD Codes.	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD codes.), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.

J1745* No No Yes No Yes No Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis code is one of the following: (View ICD Codes.). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

Use an ICD diagnosis code of (<u>View ICD Codes.</u>) as the primary detail diagnosis AND a secondary diagnosis of (<u>View ICD Codes.</u>).

The following ICD diagnosis code (<u>View ICD Codes.</u>) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No	No	No
J1756*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.
See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1786	No	2y & up	View ICD Codes.	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	No	No	003	No	No	No
J1815	No	No	No	003	No	No	No
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	003	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	View ICD Codes.	No	Yes	No	Yes
J1940	No	No	No	003	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No
J2210	No	No	No	003	No	No	No
J2248	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (<u>View ICD Codes.</u>). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J2250	No	No	No	003	No	No	No
J2260	No	No	View ICD Codes.	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical show Prior Approva		e of multiple	sclerosis m	ust be sub	mitted with the
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A F	rior Approv	al Letter is req	uired for a di	agnosis othe	r than a List	003 diagn	osis.
J2355	No	No	No	003	No	No	No
J2358	No	18y & up	No	003	No	No	No
J2360	No	No	No	003	No	No	No
J2370	No	No	No	003	No	No	No
J2400	No	No	No	003	No	No	No
J2405	No	No	No	003	No	No	No
J2410	No	No	No	003	No	No	No
J2425	No	No	No	003	No	No	No
J2426	No	18y & up	View ICD Codes.	No	No	No	No
J2430	No	No	No	003	No	No	No
J2440	No	No	No	003	No	No	No
J2460	No	No	No	003	No	No	No
J2469	No	No	No	003	No	No	No
J2501	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2503	No	No	View ICD Codes.	No	No	No	No
J2504	No	No	View ICD Codes.	No	No	No	No
J2505	No	No	Yes	003	Yes	No	No
NOTE:	Procedure cod valid ICD-9-CN or 202.80 – 20 V58.69, V67.5 cancer (List 00	diagnosis co 2.88, 288.00-2 1, V58.11, V66	de ranges 16 288.04, 288.0 2 and E933	2.0 – 165.9, 9 or 288.4 or .1 are covere	or 174.0 – 288.50-288 ed along wit	175.9 or 20 3.51 or 288 h a diagnos	1.00 – 201.98 .59, 289.53, sis of AIDS or
J2507*	No	18у & ир	View ICD	No	Yes	No	Yes

	,			-				
J2507*	No	18у & ир	Codes. 274.00-	No	Yes	No	Yes	
			274.03 or					
			274.9	V				

NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.

J2510	No	No	No	003	No	No	No
J2513	No	No	No	No	No	No	No
J2515	No	No	No	003	No	No	No
J2540	No	No	No	003	No	No	No
J2543	No	No	No	003	No	No	No
J2550	No	No	No	003	No	No	No
J2560	No	No	No	003	No	No	No
J2562	No	21y & up	No	No	No	Yes	No

NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the 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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2590	No	No	No	003	No	No	No
J2597	No	No	No	No	No	No	No
J2650	No	No	No	003	No	No	No
J2670	No	No	No	003	No	No	No
J2675	No	No	No	003	No	No	No
J2680	No	No	No	003	No	No	No
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	View ICD Codes.	No No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	View ICD Codes.	No	No	No	No

NOTE: 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	View ICD Codes.	No	No	No	No
J2916	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No
J2993	No	No	No	No	No	No	No
	Limited to 4 un catheters. Bill					ose of declo	otting
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
	Limited to 4 un catheters. Bill					ose of declo	otting
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3060*	No	18y & up	272.7	No	Yes	No	Yes
	This procedure history and phy	ysical exam wit	th a complete	e evaluation b	y a genetic	ist is require	ed each year
	Disease.	st include the p	rognosis and	d all abnorma	intes assoc	ated with G	aucher
		st include the p	No	d all abnorma	No No	No No	aucher No
	Disease.						
J3070	Disease.	No	No	003	No	No	No
J3070 J3095	No No	No 18y & up	No No	003	No No	No No	No No
J3070 J3095 J3105	No No No	No 18y & up No	No No	003 003	No No	No No	No No No
J3070 J3095 J3105 J3120	No No No No	No 18y & up No No	No No No	003 003 003 003	No No No	No No No	No No No
J3070 J3095 J3105 J3120 J3130	No No No No No No No	No 18y & up No No	No No No No	003 003 003 003 003	No No No No	No No No No	No No No No
J3070 J3095 J3105 J3120 J3130 J3140 J3150	No	No 18y & up No No No	No No No No No	003 003 003 003 003 003	No No No No No	No No No No No	No No No No No
J3070 J3095 J3105 J3120 J3130 J3140	No	No 18y & up No No No No	No No No No No No No No No	003 003 003 003 003 003	No No No No No	No No No No No	No No No No No No
J3070 J3095 J3105 J3120 J3130 J3140 J3150 J3230	No N	No 18y & up No No No No No No No	No	003 003 003 003 003 003 003	No No No No No No	No No No No No No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.
See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3262*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	No	No	003	No	No	No
J3357*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J3385*	No	4y & up	View ICD Codes.	No	Yes	No	Yes
re a _l	placement th	ediatric and adderapy. A history and phasymptoms.	ory and physic	cal exam by	a geneticist	is required	yearly for
	1.0		Vi 10D	NI-	V		
J3396	No	No	View ICD Codes.	No	Yes	No	No
	No	No		003	No	No	No No
J3400			Codes.				
J3400 J3410 J3420	No	No	No	003	No	No	No

00400	140	140	110	000	140	140	140
J3465	No	No	No	No	No	No	No
NOTE:	Procedure of	ode J3465 is	covered for no	n-pregn ant	beneficiaries	S.	
J3470	No	No	No	003	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No
J3485	No	No	No	003	No	No	No
J3489	No	No	174.0- 174.9 198.5 203.00- 203.02 203.10- 203.12 203.80- 203.82 275.42 731.0	No	No	No	No

733.00-733.09 or 733.90

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3490*	U9	16y & up	View ICD	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxy-progesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.), "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimpursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

J3520	No	No	No	003	No	No	No
J7178	No	No	View ICD Codes.	No	No	No	No
J7180	No	2y & up	View ICD Codes.	No	No	No	No
J7183	No	No	View ICD Codes.	No	No	No	No
J7185	No	21y – 65y	No	No	No	No	No
J7186	No	No	No	No	No	No	No
J7187	No	No	No	No	No	No	No
J7190	No	No	No	No	No	No	No
J7191	No	No	No	No	No	No	No
J7192	No	No	No	No	No	No	No
J7193	No	No	No	No	No	No	No
J7194	No	No	No	No	No	No	No
J7195	No	No	No	No	No	No	No
J7196	No	18y & up	View ICD Codes.	No	No	No	No
J7197	No	No	No	No	No	No	No
J7198	No	No	No	No	No	No	No
J7199*	No	No	No	No	No	No	No

NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7300	FP	No	No	No	No	No	No
NOTE:	Procedure cod physician. See					n-hospital I	pased
J7301	FP	10y & up	No	No	No	No	No
NOTE:	Procedure cod physician. See					n-hospital I	pased
J7302	No	No	617.0- 617.9 627.2 627.8 or 627.9	No	No	No	No
NOTE:	Covered for the			t of heavy me	enstrual ble	eding in wo	men who hav
J7302	FP	No	No	No	No	No	No
NOTE:	Procedure cod	le J7302 require Section 292.5				n-hospital I	oased
	priyololari. Occ					NI-	
J7303	FP FP	No	No	No	No	No	No
		le J7303 requir	es modifier F	P and is billa	able by a no		
NOTE:	FP Procedure cod	le J7303 requir	es modifier F	P and is billa	able by a no		
NOTE: J7306	FP Procedure cod physician. See	le J7303 requir e Section 292. No le J7306 requir	res modifier F 551 for detail No res modifier F	P and is billated billing info	able by a nomation. No	n-hospital I	No
NOTE: J7306 NOTE:	FP Procedure cod physician. See FP Procedure cod	le J7303 requir e Section 292. No le J7306 requir	res modifier F 551 for detail No res modifier F	P and is billated billing info	able by a nomation. No	n-hospital I	No
NOTE: J7306 NOTE: J7307	FP Procedure cod physician. See FP Procedure cod physician. See	le J7303 requir e Section 292.5 No le J7306 requir e Section 292.5 No le J7307 requir	res modifier F 551 for detaile No res modifier F 551 for detaile No res modifier F	P and is billated billing info	able by a no ormation. No able by a no ormation. No able by a no	No n-hospital t	No Dased No
NOTE: J7306 NOTE: J7307	FP Procedure cod physician. See FP Procedure cod physician. See FP Procedure cod	le J7303 requir e Section 292.5 No le J7306 requir e Section 292.5 No le J7307 requir	res modifier F 551 for detaile No res modifier F 551 for detaile No res modifier F	P and is billated billing info	able by a no ormation. No able by a no ormation. No able by a no	No n-hospital t	No Dased No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7312*	No	18y & up	View ICD Codes. 362.20	No	Yes	No	Yes
			362.30				
			362.35				
			362.36				
			363.20				

NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method.

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.

J7316*	No	18y & up	379.27	No	Yes	No	Yes

NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.

J7321	No	No	No	No	No	Yes	No	
J7323	No	No	No	No	No	Yes Yes 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 **Hyaluronon** injection in the physician's office 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. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 261.200 for Utilization Review prior authorization information. The request must include the patient's name, Medicaid ID number, physician's 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. Refer to Section 261.200 for Prior Authorization.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7330	No	No	No	No	No	Yes	No
NOTE:	Procedure cod Sections 260.0				n AFMC for	all providers	. See
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No
J7508	No	No	V42.0- V42.89	No	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
7513	No	No	No	003	No	No	No
17515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No
J7520	No	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No	No
NOTE:	For considerat name of the dr					er claim form	with the
J7527	No	18y & up	View ICD Codes.	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE:	For considerat					er claim form	with the
J8530	No	No	No	003	No	No	No
J8650*	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
19000	No	No	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9017	No	No	No	003	No	No	No
J9019*	No	2y - 18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	View ICD Codes.	No	Yes	No	Yes
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9035*	No	No	View ICD Codes.	No	Yes	No	Yes
J9040	No	No	No	003	No	No	No
J9041*	No	No	View ICD Codes.	No	Yes	No	Yes
J9042*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma diagnosis (View ICD Codes.) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043* No 18y & up <u>View ICD</u> No Yes No Yes Codes.

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003	No	No	No	
						THE RESERVE THE PARTY OF THE PA		

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9047*	No	18y & up	203.00-	No	Yes	No	Yes

NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.

J9050	No	No	No	003	No	No	No
J9055*	No	No	View ICD Codes	No	Yes	No	Yes
J9060	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9098	No	No	No	003	No	No	No
J9100	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9155	No	21y & up	No	003	No	No	No
J9160	No	No	View ICD Codes.	No	Yes	No	Yes
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	View ICD Codes.	003	Yes	No	Yes
J9179*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

J9181 N	lo No	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9185	No	No	No	003	No	No	No
J9190	No	No	No	003	No	No	No
J9200	No	No	No	003	No	No	No
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	View ICD Codes.	No	No	No	No
NOTE: Fo	r male bene	ficiaries of all a	iges. Benefit	limit is one p	procedure e	very 12 mo	onths.
J9225	No	No	View ICD Codes.	No	No	No	No
J9226*	No	0 - 12y	View ICD Codes.	No	Yes	No	Yes

NOTE: Supprelin LA: Prior to initiation of treatment, a clinical diagnosis of CPP (View ICD Codes.) should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor) and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with history and physical examination when requesting prior approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9228*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: **Ipilmumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	View ICD Codes.	No	Yes	No	Yes

NOTE: The disease must have not responded to or has relapsed following treatment with at least 2 chemotherapy regimens.

J9262*	No	18y & up	205.10-	No	Yes	No	Yes
			205 12				

NOTE: **Synribo** is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.

J9263*	No	No	View ICD Codes.	No	Yes	No	Yes
J9264*	No	No	View ICD Codes.	No	Yes	No	Yes
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9293	No	No	Yes	No	Yes	No	No
NOTE: Re	equires ICD	diagnosis code	for cancer o	r ICD diagno	sis code of	(View ICD	Codes.).
J9300	No	No	No	003	No	No	No
J9303*	No	No	View ICD Codes.	No	Yes	No	Yes
J9305*	No	No	View ICD Codes.	No	Yes	No	Yes
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: Perjeta is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with trastuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.

J9307	No	18y & up	No	003	No	No	No
J9310	No	No .	No	003	No	No	No
J9315	No	18y & up	No	003	No	No	No
J9320	No	No	No	003	No	No	No
J9328*	No	21y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: The diagnosis must be for:

 Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	View ICD Codes.	No	No	No	No	
J9340	No	No	No	003	No	No	No	
J9351	No	18y & up	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9354*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **trastuzumab** and a **taxane**, separately or in combination. Patients should have either:

received prior therapy for metastatic disease,

or

2. developed disease recurrence during or within six months of completing adjuvant therapy.

All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.

J9355	No	No	No	003	No	No	No
J9357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No
J9371*	No	18y & up	204.00- 204.02	No	Yes	No	Yes

NOTE: Marqibo is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.

J9390	No	No	No	003	No	No	No
J9395*	No	No	View ICD Codes.	No	Yes	No	Yes
J9400*	No	18y & up	153.0- 154.8	No	Yes	No	Yes

NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.

J9600	No	No	No	003	No	No	No	
J9999	No	No	No	003	Yes	No	No	
NOTE:	See Section	292.950 B fo	or coverage in	nformation.				
P9041	No	No	No	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise

Procedo Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
P9045	No	No	No	No	No	No	No
P9046	No	No	No	No	No	No	No
P9047	No	No	No	No	No	No	No
Q0139	No	No	View ICD Codes.	No	No	No	No
Q0162	UB	4y & up	No	No	No	No	No
NOTE:	QO162-UB rep	resents "Onda	nsetron 1 mg	g, oral" billab	le electronic	ally or on p	oaper.
Q0166	UB	No	No	003	No	No	No
NOTE:	Use UB modificated descriptions		Granistron H	HCI tab1mg,	oral" (Kytril). This is t	he Arkansas
Q2009	No	No	No	003	No	No	No
Q2017	No	No	No	003	No	No	No
Q2034	No	18y & up	No	No	No	No	No
Q2043*	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE:	This drug is inc castrate resista two-week inter treatment and radiology studi	ant (hormone r vals will be app documentation es showing sp	efractory) pro proved. Then n of no respon read or some	ostate cancer re must be di nse by Prosta e other metho	c. Only thre ear document of Specific of determined of determined of determined of the control o	e doses ad entation of a Antigen level ining meta	ministered at use of hormon vels, abnormal

	leukapheresis.		nedical history		sical exam is	required for	approval.
Q2049	No	18y & up	No	003	No	No	No
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4081	No	No	View ICD Codes.	No	No	No	No
Q4121	No	No	No	No	No	No	No
Q4124	No	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No	No
NOTE:	Must be billed	with manufac	cturer's invoice	attached			
Q4145*	No	No	No	No	No	No	No
NOTE:	Must be billed	with manufac	cturer's invoice	e attached			
Q9969	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
30032	No	No	No	003	No	No	No
50034	No	No	No	003	No	No	No
50039	No	No	No	003	No	No	No
50040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
50077	No	No	No	003	No	No	No
30080	No	No	No	003	No	No	No
30081	No	No	No	003	No	No	No
50092	No	No	No	003	No	No	No
50093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
50119	No	4y & up	No	No	Nø	No	No
30145	No	No	View ICD Codes.	No	No	No	No
30164	No	No	No	003	No	No	No
30177	No	No	No	003	No	No	No
50179	No	No	No	003	No	No	No
50187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No
NOTE: F	Procedure cod	e Z1847 is for	Torecan 10 r	mg oral table	ts. Limit of	(4) 10 mg tab	os per day.
90284	No	No	No	No	Yes	No	No
NOTE: 90	284 will be ap	proved for payr	ment based or	n diagnosis co	ode that prov	ves medical n	ecessity.
90375*	No	No	No	No	No	No	No
b	e attached ald	ervice must be ong with the cli mical site and fee.	inical adminis	stration recor	ds indicating	g medical ne	cessity,

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90376*	No	No	No	No	No	No	No
NOTE:	be attached a	service must be long with the cl omical site and ofee.	inical adminis	stration recor	ds indicating	g medical r	necessity,
90385	No	No	No	No	No	No	No
NOTE:	Procedure co	de 90385 is lim	ited to one in	jection per pr	regnancy.		
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose	and attach ma	nufacturer's in	nvoice.			
90632	No	19y & up	No	No	No	No	No
90633	EP, TJ	1y – 18y	No	No	No	No	No
90633	TJ	0 – 18y	No	No	No	No	No
90634	EP, TJ	1y - 18y	No	No	No	No	No
90634	TJ	1y - 18y	No	No	No	No	No
90636	EP, TJ	18y	No	No	No	No	No
90636	TJ	18y	No	No	No	No	No
90636	No	19y & up	No	No	No	No	No
90645	EP, TJ	0 - 18y	No	No	No	No	No
90645	TJ	0 - 18y	No	No	No	No	No
90645	No	19y & up	No	No	No	No	No
90646	EP, TJ	0 - 18y	No	No	No	No	No
90646	TJ	0 - 18y	No	No	No	No	No
90646	No	19y & up	No	No	No	No	No
90647	EP, TJ	0 - 18y	No	No	No	No	No
90647	TJ	0 - 18y	No	No	No	No	No
90647	No	19y & up	No	No	No	No	No
90648	EP, TJ	0 - 18y	No	No	No	No	No
90648	TJ	0 - 18y	No	No	No	No	No
90649	EP, TJ	9y - 18y	No	No	No	No	No
90649	TJ	9y - 18y	No	No	No	No	No
90650	EP, TJ	9y - 18y	No	No	No	No	No
90650	TJ	9y - 18y	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifi	er Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90654	EP, TJ	18y-18y	No	No	No	No	No
		dure is billable for of this section for a			re not pregr	nant. See S	Subsections A
90654	TJ	18y-18y	No	No	No	No	No
		dure is billable for of this section for a			re not pregr	nant. See S	Subsections A
90654	No	19y - 64y	No	No	No	No	No
		dure is billable for a for a			re not pregr	nant. See S	Subsections A
90655	EP, TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90655	TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90656	EP, TJ	3y – 18y	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90656	TJ	3y - 18y	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for addition	nal instruct	ions.	
90656	No	19y & up	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90657	EP, TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90657	TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subse	ctions A through I	of this section	on for additio	nal instruct	ions.	
90657	No	19y & up	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90658	EP, TJ	3y – 18y	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90658	TJ	3y – 18y	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	
90658	No	19y & up	No	No	No	No	No
NOTE:	See Subse	ctions A through [of this section	on for additio	nal instruct	ions.	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedo Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90660	EP, TJ	2y - 18y	No	No	No	No	No
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A
90660	TJ	2y – 18y	No	No	No	No	No
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A
90660	No	19y – 49y	No	No	No	No	No
NOTE:	This procedure through D of the				re not pregr	nant. See S	Subsections A
90662	No	65y & up	No	No	No	No	No
90669	EP, TJ	0 – 5y	No	No	No	No	No
90669	TJ	0 – 5y	No	No	No	No	No
90670	EP, TJ	0 – 5y	No	No	No	No	No
90670	TJ	0 – 5y	No	No	No	No	No
90672	EP, TJ	2y – 18y	No	No	No	No	No
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A
90672	TJ	2y – 18y	No	No	No	No	No
NOTE:	This procedure through D of th				e not pregr	ant. See S	Subsections A
90672	No	19y – 49y	No	No	No	No	No
NOTE:	This procedure through D of the				re not pregr	nant. See S	Subsections A
90673	EP, TJ	18y	No	No	No	No	No
90673	TJ	18y	No	No	No	No	No
90673	No	19y - 49y	No	No	No	No	No
90675*	No	No	No	No	No	No	No
NOTE:	Procedure cod paper claims w for each date of indicated and in must be attach	vith procedure of service. If da must be identif	code and dos ate spans are ied for each o	sage entered used, approdate within th	in Field 24 priate units e span. Th	D of claim for soft service in the contract of	orm CMS-150 must be

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90676*	No	No	No	No	No	No	No
	paper claims v for each date of indicated and	le 90676 is cov vith procedure of service. If da must be identifi ned. Reimburs	code and dos ate spans are ied for each o	sage entered e used, appro date within th	in Field 24 priate units e span. Th	D of claim for of service of manufact	orm CMS-1500 must be
90680	EP, TJ	6w - 32w	No	No	No	No	No
90680	TJ	6w - 32w	No	No	No	No	No
90681	EP, TJ	6w - 32w	No	No	No	No	No
90681	TJ	6w - 32w	No	No	No	No	No
90685	EP, TJ	6m – 35m	No	No	No	No	No
NOTE:	See Subsection	ns A through E	of this section	on for additio	nal instructi	ions.	
90685	TJ	6m – 35m	No	No	No	No	No
NOTE:	See Subsection	ns A through E	of this section	on for additio	nal instructi	ions.	
90686	EP, TJ	3y – 18y	No	No	No	No	No
		e is billable for his section for a			re not pregn	ant. See S	ubsections A
90686	TJ	3y – 18y	No	No	No	No	No
		e is billable for his section for a			re not pregr	ant. See S	ubsections A
90686	No	19y – 99y	No	No	No	No	No
		e is billable for his section for a			re not pregr	ant. See S	ubsections A
90688	EP, TJ	3y – 18y	No	No	No	No	No
		e is billable for his section for a			re not pregn	ant. See S	ubsections A
90688	TJ	3y - 18y	No	No	No	No	No
		e is billable for a			re not pregn	ant. See S	ubsections A
90688	No	19y & up	No	No	No	No	No
		e is billable for his section for a			re not pregn	ant. See S	ubsections A
90690	No	6y & up	No	No	No	No	No
90691	No	3y & up	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90692	No	No	No	No	No	No	No
90696	EP, TJ	4y – 6y	No	No	No	No	No
90696	TJ	4y – 6y	No	No	No	No	No
90698	EP, TJ	0 – 4y	No	No	No	No	No
90698	TJ	0 – 4y	No	No	No	No	No
90700	EP, TJ	0-6y	No	No	No	No	No
90700	TJ	0-6	No	No	No	No	No
90702	EP, TJ	0 – 6y	No	No	No	No	No
90702	TJ	0 – 6y	No	No	No	No	No
90703	No	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No	No
90705	No	9m & up	No	No	No	No	No
90706	No	1y & up	No	No	No	No	No
90707	U1	21y - 44y	No	No	No	No	No

NOTE: Procedure code 90707 is payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime. U1 modifier is required for this age group.

90707	EP, TJ	0 – 18y	No	No	No	No	No	
90707	TJ	0 – 18y	No	No	No	No	No	
90707	No	19y – 20y	No	No	No	No	No	
90708	No	0 - 99y	No	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90710	EP, TJ	0 – 18y	No	No	No	No	No
90710	TJ	0 – 18y	No	No	No	No	No
90710	No	0 – 20y	No	No	No	No	No
90712	No	0 – 20y	No	No	No	No	No
90713	EP, TJ	0 – 18y	No	No	No	No	No
90713	TJ	0 - 18y	No	No	No	No	No
90713	No	19y & up	No	No	No	No	No
90714	EP, TJ	7y – 18y	No	No	No	No	No
90714	TJ	7y – 18y	No	No	No	No	No
90714	No	19y & up	No	No	No	No	No
90715	EP, TJ	7y – 18y	No	No	No	No	No
90715	TJ	7y – 18y	No	No	No	No	No
90715	No	19y & up	No	No	No	No	No
90716	EP, TJ	0 – 18y	No	No	No	No	No
90716	TJ	0 – 18y	No	No	No	No	No
90716	No	0 – 20y	No	No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: Su	bmit invoice	with claim.					
90719	No	No	No	No	No	No	No
90720	EP, TJ	0 - 18y	No	No	No	No	No
90720	TJ	0 - 18y	No	No	No	No	No
90720	No	0 - 20y	No	No	No	No	No
90721	EP, TJ	0 - 18y	No	No	No	No	No
90721	TJ	0 - 18y	No	No	No	No	No
90721	No	1y - 20y	No	No	No	No	No
90723	EP, TJ	0 - 18y	No	No	No	No	No
90723	TJ	0 - 18y	No	No	No	No	No
90725*	No	No	No	No	No	No	No
NOTE: Su	bmit manufa	acturer's invoic	e.				
90727*	No	No	No	No	No	No	No
NOTE: Su	hmit manufa	acturer's invoic	Δ.				

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (<u>View ICD Codes.</u>). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
90732	EP, TJ	2y – 18y	No	No	No	No	No
90732	TJ	2y – 18y	No	No	No	No	No
90732	No	2y & up	No	No	No	No	No
		1 years and old h risk. All ben					
90733	No	No	No	No	No	No	No
90734	EP, TJ	0 - 18y	No	No	No	No	No
90734	TJ	0 - 18y	No	No	No	No	No
90734	No	19y & up	No	No	No	No	No
90735	No	0 - 20y	No	No	No	No	No
90736	No	60y & up	No	No	No	No	No
NOTE: Zo	ster vaccine	is benefit limit	ed to once in	a lifetime.			
90740	No	No	No	No	No	No	No
90743	EP, TJ	0 - 18y	No	No	No	No	No
90743	TJ	0 - 18y	No	No	No	No	No
90744	EP, TJ	0 - 18y	No	No No	No	No	No
90744	TJ	0 - 18y	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
90747	EP, TJ	0 - 18y	No	No	No	No	No
90747	TJ	0 - 18y	No	No	No	No	No
90747	No	19y & up	No	No	No	No	No
90748	EP, TJ	0 - 18y	No	No	No	No	No
90748	TJ	0 - 18y	No	No	No	No	No
90748	No	19y & up	No	No	No	No	No
90749*	No	No	No	No	No	No	No
pro	ovided (drug	r procedure co , dose, route o uding documer	f administrati	on) as well a	s clinical no		
96379*	No	No	No	No	No	No	No
pro	ovided (drug	r procedure co , dose, route o uding documer	f administrati	on) as well a	s clinical no		

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

A. Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379 and 96401 through 96549 for therapeutic and chemotherapy administration procedure codes.

See Section 292,940 for radiopharmaceutical drugs.

- B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:
 - 1. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
 - 2. Documentation that further describes the drug provided must be attached and must include justification for medical recessity.
 - 3. All other billing requirements must be met in order for payment to be approved.

C. Immunizations

Physicians may bill for immunization procedures on the CMS-1500 claim form. View a CMS-1500 sample form. See Sections 292 920, 292,930 and 292.950 for covered vaccines and billing protocols.

D. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- 1. The <u>first</u> column of the list contains the CPT or HCPCS procedure codes.
- 2. The <u>second</u> column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
- 3. The <u>third</u> 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).
- 4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
- 5. The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
- 6. The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)
- 8. The <u>eighth</u> 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. <u>View contact information for the Medical Director for Clinical Affairs</u> for the Division of Medical Services.

C9287*

No

18y & up

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
A9580*	No	No	View ICD Codes.	No	No	No	No
<u>C</u>	Procedure cod Codes.). Requadiopharmace	e A9580 is pay uires a paper d euticals.	able for ben laim with ma	eficiaries with nufacturer's	n a primary invoice ider	diagnosis on tifying the o	of (View ICD cost of the
A9585	No	2y & up	No	No	No	No	No
A9586	No	18y & up	View ICD Codes.	No	No	No	No
C8931	No	No	No	No	No	No	No
C8932	No	No	No	No	No	No	No
C8934	No	No	No	No	No	No	No
C8935	No	No	No	No	No	No	No
C8936	No	No	No	No	No	No	No
C9141	No	6m & up	No	No	No	No	No
C9248	No	No	No	No	No	No	No
C9254	No	18y & up	No	No	No	No	No
C9257*	No	21y & up	Yes	No 🐧	Yes	No	Yes
d re	iagnosis code equest must ir	rocedure code es (View ICD C nclude Fluoros dicate the use	cein angiogra	cumentation in am or OCT, p	ncluded with atient scree	h Prior App en for condi	roval Letter itions that
C9286	No	18y & up	View ICD Codes.	No	No	No	No

NOTE: This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multiagent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. Prior approval letter requests should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. The discussion of risk of PML should be documented in medical records.

No

Yes

No

Yes

View ICD

Codes.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9292	No	18y & up	View ICD Codes.	No	No	No	No
C9294*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: A complete medical exam with history is required and must be submitted with a yearly evaluation by a geneticist. Prognosis should be documented as well as all prior treatments. If prior treatment is Imigliucerase, the dose and outcome of treatment should be included.

C9295	No	18y & up	View ICD Codes.	No	No	No	No
C9296*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This procedure code is used in combination with 5-fluorouracil, leucovorin and irinotecan (FOLFIRI) in patients with metastatic colorectal cancer (mCRC) that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam must be sent with all previous treatments noted. Hemorrhage, gastrointestinal perforation and compromised wound healing are all complications of this procedure code and should be evaluated.

C9363	No	No	View ICD Codes.	No	No	No	No
C9733	No	No	No	No	No	No	No
J0120	No	No	No	003	No	No	No
J0129*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: Patient must have had inadequate response to one or more disease-modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam
showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic
drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis,
etc.

No	No	View ICD Codes.	No	No	No	No
No	No	No	No	No	No	No
Maximum u	nits allowed a	are 4 per day.				
No	No	No	No	No	No	No
	No Maximum ui	No No Maximum units allowed a	No No No Maximum units allowed are 4 per day.	No No No No Maximum units allowed are 4 per day.	No No No No No Maximum units allowed are 4 per day.	No No No No No No No Maximum units allowed are 4 per day.

NOTE: When administered in the office, the provider must have nursing staff available to monitor the patient's vital signs during infusion. The provider must be able to treat cardiac shock and to provide advanced cardiac life support in the treatment area where the drug is infused. Can be billed electronically or on paper. Maximum units 1 per day.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0171	No	No	No	No	No	No	No
J0178*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.

	Allalis for a	noi Appiov	di lottor.				
J0180*	No	No	View ICD Codes.	No	No	No	Yes
NOTE:	Procedure of code of (Vie		s covered for treats.).	tment of I	Fabry's disea	se, with an IC	CD diagnosis
J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	No	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	View ICD Codes.	No	No	No	Yes
NOTE:	Evaluation b annually.	y a physiciar	n with a specialty	in clinica	I genetics do	cumenting pr	ogress require
J0256	No	No	View ICD	No	No	No	No

Codes.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0257	No	18y & up	View ICD Codes.	No	No ·	No	No

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha 1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No
J0280	No	No	No	003	No	No	No
J0285	No	No	No	003	No	No	No
J0287	No	No	No	003	No	No	No
J0288	No	No	No	003	No	No	No
J0289	No	No	No	003	No	No	No
J0290	No	No	No	003	No	No	No
J0295	No	No	No	003	No	No	No
J0300	No	No	No	003	No	No	No
J0330	No	No	No	003	No	No	No
J0348	No	No	Yes	003	No	No	No

NOTE: Procedure code J0348 is valid for any condition below, along with an ICD diagnosis code of (View ICD Codes.): (1) End-stage Renal Disease or (2) AIDS or Cancer or (3) Post transplant status or specify transplanted organ and transplant date.

03 No No No
03 No No No
03 No No No
03 No No No
0

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0461	No	No	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	View ICD Codes.	No	No	No	No
J0485	No	18y & up	View ICD Codes.	No	No	No	No
J0490	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.

J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is re	eviewed for med	dical neces	sity based or	ICD diagnos	sis code.	
J0586	No	No	No	No	Yes	No	No
NOTE:	This proced billed.	ure code is revi	ewed for m	nedical neces	sity based or	an ICD diag	nosis code
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD diag	nosis code which	ch supports	s medical nec	essity is requ	uired.	
J0592	No	No	No	003	No	No	No
J0595	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J0597*	No	13y & up	View ICD Codes.	No	No	No	No
	is code will I bmitted.	be reviewed fo	r medical ne	cessity based	on the clin	ical docum	entation
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
J0630	No	No	No	003	No	No	No
J0636	No	No	View ICD Codes.	No	No	No	No

NOTE: Procedure code J0637 is covered when administered to patients with refractory aspergillosis who also have a diagnosis of malignant neoplasm or HIV disease. Complete history and physical exam, documentation of failure with other conventional therapy and dosage. After 30 days of use, an updated medical exam and history must be submitted.

No

Yes

No

	_							
J0638	No	4y &up	View ICD Codes.	No	No	No	No	
J0640	No	No	No	003	No	No	No	
J0641*	No	No	View ICD Codes.	No	Yes	No	Yes	

NOTE: Approved Only:

J0637*

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

						-	
J0670	No	No	No	003	No	No	No
J0690	No	No	No	003	No	No	No
J0692	No	No	No	003	No	No	No
J0694	No	No	No	003	No	No	No
J0696	No	No	No	003	No	No	No
J0697	No	No	No	003	No	No	No
J0698	No	No	No	003	No	No	No
J0702	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code (<u>View ICD Codes.</u>) for complications of pregnancy or List 003 for all ages.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

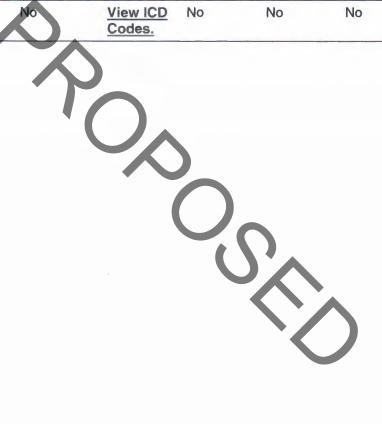
*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0706	No	No	No	003	No	No	No
J0710	No	No	No	003	No	No	No
J0712	No	18y & up	No	No	No	No	No
J0713	No	No	No	003	No	No	No
J0715	No	No	No	003	No	No	No
J0716	No	No	View ICD Codes.	No	No	No	No



See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0718*	No	18y & up	No	No	Yes	No	Yes

NOTE: 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

o 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.

J0720	No	No	No	003	No	No	No
J0725	No	No	No	003	No	No	No
J0735	No	No	No	003	No	No	No
J0740	No	No	No	003	No	No	No
J0743	No	No	No	003	No	No	No
J0744	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0745	No	No	No	003	No	No	No
J0760	No	No	No	003	No	No	No
J0770	No	No	No	003	No	No	No
J0780	No	No	No	003	No	No	No
J0795	No	No	No	003	No	No	No
J0800	No	No	No	003	No	No	No
J0833	No	No	No	No	No	No	No
J0834	No	No	No	No	No	No	No
J0850	No	No	No	003	No	No	No

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881 J0885	No	No	Yes; see below	No	No	No	No

NOTE: For all diagnoses, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

In addition to the primary diagnosis, an ICD diagnosis code from each column below must be billed on the claim.

Column I	Column	Column II				
	Code	Description				
Secondary Anemia View ICD codes.)	View ICD Codes.	Encounter for antineoplastic chemotherapy				
	View ICD Codes.	Following chemotherapy				
	View ICD Codes.	Antineoplastic and immunosuppressive drugs				

Use ICD code (<u>View ICD Codes.</u>) (primary) with (<u>View ICD Codes.</u>) (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

		Column I		Column	II		
				Code	Description		
	Anemia of other chronic disease (View ICD codes.)		View Chronic Hepatitis C without mention of coma Codes.		mention of coma		
				View ICD Codes.	Myelodyspla	astic	
				View ICD Codes.	Rheumatoid Arthritis		
J0882	No	No	View ICD Codes.	No	No	No	No
10005							

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
NOTE:	See procedure	code J0881 ir	n this section	for specific o	riteria.		
J0886	No	No	View ICD Codes.	No	No	No	No
J0894*	No	No	View ICD Codes.	No	No	No	Yes
J0895	No	No	No	No	No	No	No
J0897*	No	18y & µp	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (View ICD Codes.). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer (View ICD Codes.) or adjuvant aromatase inhibitor therapy for breast cancer (View ICD Codes.). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

Code		Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	٨	10y & up	۸	No	No	No	No
۸	therapeutic u	ered for therape se, a diagnosis ng, a FP modifie	and clinical re	ecords must	justify the tr	eatment. \	When billed for
NOTE:	11976 and 58 related to pos	ost occlusion by 3301 are payabl st-58565 service fee for the 585	e family planes during the	ning services six months fo	for non-ste	rile female procedure	s only. All visits are included in

J1060	No	No	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code from the following range of ICD codes (View ICD Codes.) for complications of pregnancy or List 003 for all ages.

J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No
J1267	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below :

- A valid ICD diagnosis from list 003 or a valid ICD code of the following renal failure code range (View ICD Codes.).
- Plus at ICD diagnosis from the following code range (View ICD Codes.).

Plus an ICD diagnosis of (View ICD Codes.).

J1300	No	No	View ICD Codes.	No	No	No	No
J1320	No	No	No	003	No	No	No
J1325	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1440	No	No	No	No	No	No	No
J1441	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	View ICD Codes.	No	No	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No
J1557	No	2y & up	No	No	Yes	No	No
NOTE:	An ICD diag	nosis code that	supports med	ical neces	sity is requir	ed.	
J1559	No	4y & up	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diag	nosis code	billed.
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diag	nosis code	billed.
J1568	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diagi	nosis code	billed.
J1569	No	No	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diag	nosis code	billed.
J1570	No	No	No	003	No	No	No
J1580	No	No	No	003	No	No	No
J1590	No	No	No	003	No	No	No
J1599	No	4y & up	No	No	Yes	No	No
NOTE:	Claims are rev	iewed for med	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1600	No	No	View ICD Codes.	No	No	No	No
J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	View ICD Codes.	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No	No	003	No	No	No
			Ma	002	No	Ma	No
J1670	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No
J1725	No	16y & up	View ICD Codes.	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	View ICD	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.

J1745* No No Yes No Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis code is one of the following: (View ICD Codes.). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

Use an ICD diagnosis code of (<u>View ICD Codes.</u>) as the primary detail diagnosis AND a secondary diagnosis of (<u>View ICD Codes.</u>).

The following ICD diagnosis code (<u>View ICD Codes.</u>) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No ,	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1756*	No	18y & up	View ICD Codes.	No	Yes	No	Yes
J1786	No	2y & up	View ICD Codes.	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	No	No	003	No	No	No
J1815	No •	No	No	003	No	No	No
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	008	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	View ICD Codes.	No	Yes	No	Yes
J1940	No	No	No	003	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).
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See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J2210	No	No	No	003	No	No	No
J2250	No	No	No	003	No	No	No
J2260	No	No	View ICD Codes.	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical show Prior Approva		e of multiple	sclerosis m	ust be sub	mitted with the
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
		No al Letter is req					
NOTE: A F							
NOTE: A F	Prior Approv	al Letter is req	uired for a di	agnosis othe	r than a List	003 diagn	osis.
J2354* NOTE: A F J2355 J2358 J2360	Prior Approv	al Letter is req	uired for a di	agnosis othe	rthan a List	003 diagn	osis.
NOTE: A F J2355 J2358 J2360	Prior Approv No No	al Letter is req No 18y &up	uired for a di No No	agnosis othe 003 003	No No	No No	No No
NOTE: A F J2355 J2358 J2360 J2370	Prior Approv No No No	al Letter is req No 18y &up No	uired for a di No No No	agnosis othe 003 003 003	No No No	No No No	No No No
NOTE: A F J2355 J2358 J2360 J2370 J2400	Prior Approv No No No No	al Letter is req No 18y &up No No	uired for a dia No No No No	agnosis othe 003 003 003 003	No No No No	No No No No	No No No No
NOTE: A F J2355 J2358	Prior Approv No No No No No	al Letter is req No 18y &up No No No	uired for a dia No No No No No	agnosis othe 003 003 003 003 003	No No No No No	No No No No No No	No No No No No
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405	Prior Approv No No No No No No No No No	Al Letter is req No 18y &up No No No No	uired for a dia No No No No No No No	agnosis othe 003 003 003 003 003 003	No N	No No No No No No	No No No No No No
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425	Prior Approv No	al Letter is req No 18y &up No No No No No	No	agnosis othe 003 003 003 003 003 003 003	No N	No No No No No No No	No
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405 J2410	Prior Approv No	Al Letter is req No 18y &up No No No No No No	No N	agnosis othe 003 003 003 003 003 003 003 00	No N	No No No No No No No No	No
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426	Prior Approv No	al Letter is req No 18y &up No	No View ICD Codes.	agnosis othe 003 003 003 003 003 003 003 00	No N	No No No No No No No No	No N
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426 J2430	Prior Approv No	Al Letter is req No 18y & up No	No No No No No No No No No View ICD Codes.	agnosis othe 003 003 003 003 003 003 003 00	No N	No No No No No No No No	No N
NOTE: A F J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426 J2430 J2440	Prior Approv No	Al Letter is req No 18y &up No	uired for a dia No No No No No No No No View ICD Codes. No	agnosis othe 003 003 003 003 003 003 003 No 003 003	No N	No N	No N

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures. See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2503	No	No	View ICD Codes.	No	No	No	No
J2504	No	No	View ICD Codes.	No	No	No	No
J2505	No	No	Yes	003	Yes	No	No
		le J2505 is pay Diagnosis cod					agnosis (<u>View</u>
J2507*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.

J2510	No	No	No	003	No	No	No	
J2513	No	No	No	No	No	No	No	
J2515	No	No	No	003	No	No	No	
J2540	No	No	No	003	No	No	No	
J2543	No	No	No	003	No	No	No	
J2550	No	No	No	003	No	No	No	
J2560	No	No	No	003	No	No	No	
J2562	No	21y & up	No	No	No	Yes	No	

NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the 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.

J2590	No	No	No	003	No	No	No
J2597	No	No	No	No	No	No	No
J2650	No	No	No	003	No	No	No
J2670	No	No	No	003	No	No	No
J2675	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol)

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2680	No	No	No	003	No	No	No
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	View ICD Codes,	No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	View ICD Codes.	No	No	No	No

NOTE: Beneficiaries must have failed corticosteroids, immunoglobulins of 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	View ICD Codes.	No	No	No	No
J2916	No	No	No	No	No	No	No
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2993	No	No	No	No	No	No	No
		nits per day in t ICD diagnosis				ose of dec	lotting
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
		nits per day in t ICD diagnosis				ose of dec	elotting
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3070	No	No	No	003	No	No	No
J3095	No	18y & up	No	003	No	No	No
J3105	No	No	No	003	No	No	No
J3120	No	No	No	003	No	No	No
J3130	No	No	No	003	No	No	No
J3140	No	No	No	003	No	No	No
J3150	No	No	No	003	No	No	No
J3230	No	No	No	003	No	No	No
J3240	No	No	No	003	No	No	No
J3250	No	No	No	003	No	No	No
J3260	No	No	No	003	No	No	No
J3262*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	Nø	No	003	No	No	No
J3357*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No
J3385*	No	4y & up	View ICD	No	Yes	No	Yes

NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. A history and physical exam by a geneticist is required yearly for approval. The history and physical exam should document the prognesis of the patient as well as current symptoms.

	Well as call	on Symptom					
J3396	No	No	View ICD Codes.	No	Yes	No	No
J3400	No	No	No	003	No	No	No
J3410	No	No	No	003	No	No	No
J3420	No	No	View ICD Codes.	No	No	No	No
J3430	No	No	No	003	No	No	No
J3465	No	No	No	No	No	No	No
NOTE:	Procedure of	ode J3465 is	covered for non	-pregnant	beneficiaries	3.	
J3470	No	No	No	003	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3485	No	No	No	003	No	No	No
J3487	No	No	Yes	003	Yes	No	No
NOTE: Pro	cedure cod	e J3487 is vali	id with a prim	ary ICD diag	nosis of (Vi	ew ICD Cod	des.).
J3488	No	No	No	No	No	No	No
J3490*	U9	16y & up	View ICD Codes.	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxy-progesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.) "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

J3520	No	No	No	003	No	No	No
J7178	No	No	View ICD Codes.	No	No	No	No
J7180	No	2y & up	View ICD Codes.	No	No	No	No
J7183	No	No	View ICD Codes.	No	No	No	No
J7185	No	21y – 65y	No	No	No	No	No
J7186	No	No	No	No	No	No	No
J7187	No	No	No	No	No	No	No
J7190	No	No	No	No	No	No	No
J7191	No	No	No	No	No	No	No
J7192	No	No	No	No	No	No	No
J7193	No	No	No	No	No	No	No
J7194	No	No	No	No	No	No	No
J7195	No	No	No	No	No	No	No
J7196	No	18y & up	View ICD Codes.	No	No	No	No
J7197	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Proced Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J7198	No	No	No	No	No	No	No
J7199*	No	No	No	No	No	No	No
NOTE:	For considerar	tion, procedure rug, dosage an				er claim for	m with the
J7300	FP	No	No	No	No	No	No
NOTE:	Procedure coophysician. Se	de J7300 requir e Section 292.	res modifier F 551 for detail	P and is billa ed billing info	able by a no ormation.	n-hospital	based
J7302	FP	No	No	No	No	No	No
NOTE:	Procedure coophysician. Se	de J7302 requir e Section 292.	res modifier F 551 for detail	P and is billa ed billing info	able by a no rmation.	n-hospital	based
J7303	FP	No	No	No	No	No .	No
NOTE:	Procedure coophysician. Se	de J7303 requir e Section 292.				n-hospital	based
J7306	FP	No	No	No	No	No	No
NOTE:	Procedure coophysician. Se	de J7306 requir e Section 292.				n-hospital	based
J7307	FP	No	No	No	No	No	No
NOTE		de J7307 requir e Section 292.				n-hospital	based
NOTE:	priysician. Oc					A .	
J7308	No No	No	No	003	No	No	No
		No No	No No	003	No	No	No No

NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method.

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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

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 **Hyaluronon** injection in the physician's office 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. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 261.200 for Utilization Review prior authorization information. The request must include the patient's name, Medicaid ID number, physician's 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. Refer to Section 261.200 for Prior Authorization.

	illese illjecii	on procedure	33. Helel to 3	5011011201.20	ל וטו ו ווטו ה	dirionzation.	
J7330	No	No	No	No	No	Yes	No
NOTE:			equires prior a 00, 261.100 ar		rom AFMC f	or all provide	rs. See
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
J7513	No	No	No	003	No	No	No
J7515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No
J7520	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J7525*	No	No	No	No	Yes	No	No
NOTE:	For considerat name of the dr					er claim for	m with the
J7527	No	18y & up	View ICD Codes.	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE:	For considerat name of the dr					er claim for	m with the
J8530	No	No	No	003	No	No	No
J8650*	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
J9000	No	No	No	003	No	No	No
J9002	No	18y & up	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No
J9017	No	No	No	003	No	No	No
J9019*	No	2y-18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	View ICD Codes.	No	No	No	Yes
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9035*	No	No	View ICD Codes.	No	Yes	No	Yes
J9040	No	No	No	003	No	No	No
J9041*	No	No	View ICD Codes.	No	Yes	No	Yes

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9042*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma diagnosis (View ICD Codes.) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043* No 18y & up View ICD No Yes No Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003	No	No	No
J9050	No	No	No	003	No	No	No
J9055*	No	No	View ICD Codes.	No	Yes	No	Yes
J9060	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9098	No	No	No	003	No	No	No
J9100	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9155	No	21y & up	No	003	No	No	No
J9160	No	No	View ICD Codes.	No	Yes	No	Yes

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	View ICD Codes.	003	Yes	No	Yes
J9179*	No	18y & up	View ICD Codes	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

J9181	No	No	No	003	No	No	No
J9185	No	No	No	003	No	No	No
J9190	No	No	No	003	No	No	No
J9200	No	No	No	003	No	No	No
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No ·	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	View ICD	No	No	No	No

NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J9225	No	No	View ICD Codes.	No	No	No	No
J9226*	No	0-12y	View ICD Codes.	No	Yes	No	Yes

NOTE: Supprelin LA: Prior to initiation of treatment, a clinical diagnosis of CPP (View ICD Codes.) should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor) and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with history and physical examination when requesting prior approval.

J9228* No 18y & up View ICD No Yes No Yes Codes.

NOTE: **Ipilmumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not irreatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: The disease must have not responded to or has relapsed following treatment with at least 2 chemotherapy regimens.

J9263*	No	No	View ICD	No	Yes	No	Yes	
			Codes.					

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J9264*	No	No	View ICD Codes.	No	Yes	No	Yes
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No
10000	No	No	Yes	No	Yes	No	No
J9293	140	140	. 00				
		diagnosis code				(View ICD	Codes.).
NOTE: Red						(View ICD No	Codes.).
NOTE: Red J9300	quires ICD	diagnosis code	for cancer o	r ICD diagno	sis code of		
NOTE: Red J9300 J9303*	quires ICD (diagnosis code	No View ICD	r ICD diagno	sis code of	No	No
NOTE: Red J9300 J9303* J9305*	No No	No No	View ICD View ICD	r ICD diagno 003 No	No Yes	No No	No Yes
J9293 NOTE: Rec J9300 J9303* J9305* J9307 J9310	No No No No	No No No	View ICD Codes.	r ICD diagno 003 No	No Yes Yes	No No	No Yes Yes
NOTE: Red J9300 J9303* J9305* J9307	No No No No	No No No No 18y & up	View ICD Codes. No	r ICD diagno 003 No No	No Yes Yes No	No No No	No Yes Yes
NOTE: Red J9300 J9303* J9305* J9307 J9310	No No No No No No	No	View ICD Codes. View ICD Codes. No No	No No 003	No Yes Yes No	No No No No	No Yes Yes No

NOTE: The diagnosis must be for:

Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	View ICD Codes.	No	No	No	No
J9340	No	No	No	003	No	No	No
J9351	No	18y & up	No	003	No	No	No
J9355	No	No	No	003	No	No	No
J9357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J9390	No	No	No	003	No	No	No
J9395*	395* No No		View ICD Codes.	No	Yes	No	Yes
J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No
NOTE: Se	ee Section 29	92.950 B for co	overage infor	mation.			
P9041	No	No	No	No	No	No	No
P9045	No	No	No	No	No	No	No
P9046	46 No No		No	No	No	No	No
P9047	No	No	No	No	No	No	No
Q0139	No	No	View ICD Codes.	No	No	No	No
Q0162	UB	4y & up	No	No	No	No	No
NOTE: Q	0162-UB rep	oresents "Onda	ansetron 1 mg	g, orai" billab	le electronic	cally or on	paper.
Q0166	UB	No	No	003	No	No	No
	se UB modifi edicaid desc	er for Q0166 – ription.	"Granistron H	HCI tab1mg,	oral" (Kytril). This is t	he Arkansas
Q2009	No	No	No	003	No	No	No
Q2017	No	No	No	003	No	No	No
Q2034	No	18y & up	No	No	No	No	No
Q2043*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.

Q2049	No	18y & up	No	003	No	No	No
Q3025	No	No	No	No	No	No	No
Q3026	No	No	No	No	No	No	No
Q4081	No	No	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
Q4124	No	No	No	No	No	No	No
Q9969	No	No	No	No	No	No	No
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
S0032	No	No	No	003	No	No	No
S0034	No	No	No	003	No	No	No
S0039	No	No	No	003	No	No	No
S0040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
S0077	No	No	No	003	No	No	No
S0080	No	No	No	003	No	No	No
S0081	No	No	No	003	No	No	No
S0092	No	No	No	003	No	No	No
S0093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
S0119	No	4y & up	No	No	No	No	No
S0145	No	No	View ICD Codes.	No	No	No	No
S0164	No	No	No	003	No	No	No
S0177	No	No	No	003	No	No	No
S0179	No	No	No	003	No	No	No
S0187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No
NOTE: Pro	cedure cod	e Z1847 is for	Torecan 10 r	ma oral table	ts. Limit of	(4) 10 mg t	abs per day

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90284	No	No	No	No	Yes	No	No
NOTE: 9	0284 will be ap	proved for payr	ment based or	n diagnosis co	ode that prov	ves medical	necessity.
90375*	No	No	No	No	No	No	No
	be attached ald	ervice must be ong with the cli mical site and fee.	nical adminis	stration recor	ds indicatin	g medical n	ecessity,
90376*	No	No	No	No	No	No	No
	be attached ale	ervice must be ong with the cli mical site and fee.	nical adminis	stration recor	ds indicatin	g medical n	ecessity,
90385	No	No	No	No	No	No	No
NOTE:	Procedure cod	le 90385 is limi	ted to one in	ection per pr	regnancy.		
0386	No	No	No	No	No	No	No
0581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose a	and attach mar	nufacturer's in	nvoice.			
0632	No	19y & up	No	No	No	No	No
0662	No	65y & up	No	No	No	No	No
		le 90662 is cov		eficiaries age	es 65 years	and older fo	or dates of
90675*	No	No	No	No	No	No	No
	paper claims w for each date c indicated and r	le 90675 is covith procedure of service. If damust be identified. Reimburs	code and dos ate spans are ied for each o	sage entered e used, appro date within th	in Field 24 priate units e span. Th	D of claim f of service e manufact	orm CMS-150 must be
90676*	No	No	No	No	No	No	No
	paper claims w for each date c indicated and r	le 90676 is cov vith procedure of service. If da must be identifi ied. Reimburs	code and dos ate spans are ied for each o	sage entered e used, appro date within th	in Field 24 opriate units e span. Th	D of claim f of service e manufact	orm CMS-150 must be
90690	No	6y & up	No	No	No	No	No
0691	No	3y & up	No	No	No	No	No
90703	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

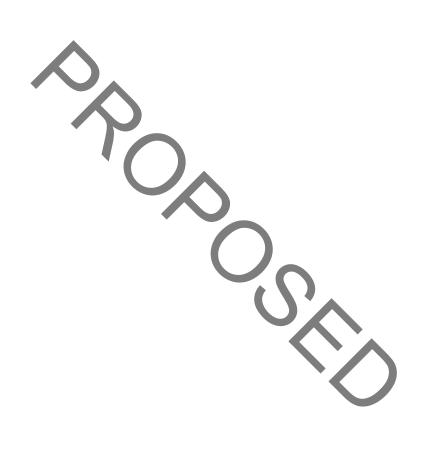
Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90704	No	1y & up	No	No	No	No	No
90705	No	9m & up	No	No	No	No	No
90706	No	1y & up	No	No	No	No	No
90707	U1	21y - 44y	No	No	No	No	No
ti	nrough 44, wh	e 90707 is pay to may be at ri- ifetime. U1 mo	sk of exposui	re to these di	seases. Co		
90707	No	19y - 20y	No	No	No	No	No
90708	No	9m & up	No	No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: S	Submit invoice	with claim.	()				
90719	No	No	No	No	No	No	No
90725*	No	No	No	No	No	No	No
NOTE: 5	Submit manufa	cturer's invoic	e.				
90727*	No	No	No	No	No	No	No
NOTE: S	Submit manufa	cturer's invoic	e.				
90732	No	2y & up	No	No	No	No	No
		1 years and ole h risk. All ben					
90733	No	No	No	No	No	No	No
90735	No	0 - 20y	No	No	No	No	No
90740	No	No	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
96379*	No	No	No	No	No	No	No
		r procedure co , dose, route o		on) as well a	s clinical no		

procedure including documentation of medical necessity.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

Hyperalimentation Section II



TOC not required

292.910 National Drug Codes (NDCs)

11-1-0810-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website Arkansas Medicaid web page at www.medicaid.state.ar.us, click on Provider Services, select Prescription Drug information, and then select Covered Labelers. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	741761
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELE	R PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits) (4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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	01111 0 456 7 1

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

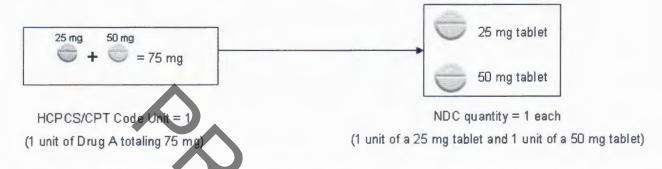
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

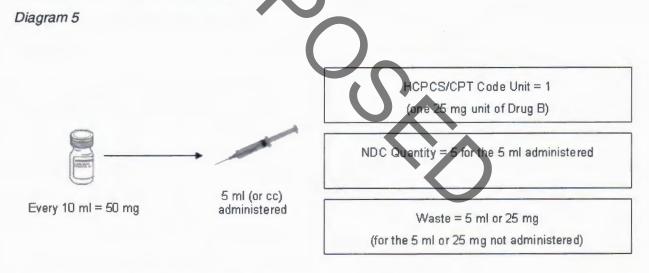
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Filing – 837P (Professional) and 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 requires 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 837P professional claims, from the Service 2 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 https://www.medicaid.state.ar.us/. Click on Provider, select HIPAA, select Documents for Vendors and then select Companion Guides.

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	DA. A.	From EID	ATE(B)	1252	T-0	44	PLACE CHE SIGNATURE	6340	(Explain) CPTHOPCS	musuali	Cesurouts	issaaj Soff (E)	i.	A SALLES	1 (0447)	45	OPICS CAR CARTS	Sales to the sales	SERVE.	RENDERFOLD PROVEGA 6. #
1	N4 08	1234	5	108 108	UN O1	1.00	111		Z1234	1	1		6	14	25	100	4	1	HPI	123456759
Sequence 2	3	0111	A	2233	A	1.00	Ammin	berrarra	<u> </u>			·	·······\$		Marin Marin			.å	349-3	123456789
2.	08	01	5	08	01		111	0.00	Z1234	1	90.00 A			11		2 00	0		16891	
Detail 2 3		1	ŧ		4	1	4	4		8	è		1					á		123466789
	08 N4	201		908	ML	500	111		99213				L		- 55	00		.l	MPI	123458789
Sequence 1 4	08	01			01		11	-	28789	1	1		1	[1]	36	100	1		1684	en engrencións en de sels del derritos de en s
Detail 3 5	South Attent	MANNAY MANNAMAN	PER 4 40000 NOVE	ogh-ir-time ~	Aprilia 16000	angarleton (CCC) (Male	age continues to contra	plik meledagi	Entonomic .						1000	occopide: Artifery	Beendy Association	20800000000		CONTROL OF THE PROPERTY OF THE

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 7 for an example of the completed form. A copy of form DMS-664 is attached and may be copied for claim submission. Copies of the DMS-664 will not be provided. Section V of the provider manual will be updated to include includes this form.

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

III. 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.

IV. 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.

V. 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," then select "Prescription Drug Information" and then select "DESI NDCs (non-payable) associated with HCPCS/CPT Codes." See Diagram 8 for an example of the DESI list.

Diagram 8

	DESI NDCs (non	ARKANSAS MEDICAID -payable) associated with HO	CPCS/CPT Codes	als Table 14 15
Eo	A STATE OF THE STA		Help Desk 1-800-707-3854	1
FU	i idialet miormanon bi	lease contact LD3 i naimacy	Helb Deak 1-000-101-3034	
	r tarater information pr	rease contact CD3 F narmacy		ed 10/15/200
NDC	DESI Drug Begin Date			

VI. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 292.950 for additional information regarding drug code billing.

292.950 Injections, Therapeutic and/or Diagnostic Agents

2-15-15<u>10-</u> 1-15

A. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code, T1502 is payable for beneficiaries of all ages. **T1502** may be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "ORALLY." No fee is billable for drugs administered orally.

T1502 cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

T1502 cannot be billed to administer any medication given for family planning purposes. No other fee is billable when the provider decides not to supply family planning injectable medications.

T1502 cannot be billed when the drug administered is not FDA approved.

See the table below when billing T1502:

Procedure Code	Modifier	Eligibility Category
T1502	EP	ARKids-A (Ages 0-20)
T1502		ARKids-B
T1502		Ages 19 and above

Most of the covered drugs can be billed electronically. However, any covered drug marked with an asterisk (*) must be billed on paper with the name of the drug and dosage listed in the "Procedures, Services, or Supplies" column, Field 24D, of the CMS-1500 claim form. View a CMS-1500 sample form. If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

See Section 292.940 for coverage information of radiopharmaceutical procedure codes.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 292.910 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only

one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379 and 96401 through 96549 for therapeutic and chemotherapy administration procedure codes.

See Section 292.940 for radiopharmaceutical drugs.

- B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:
 - The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
 - 2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
 - 3. All other billing requirements must be met in order for payment to be approved.

C. Immunizations

Physicians may bill for immunization procedures on the CMS-1500 claim form. <u>View a</u> CMS-1500 sample form. See Section 292.950 for covered vaccines and billing protocols.

Coverage criteria for all immunizations and vaccines are listed in Part E of this section.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and obviously which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. Vaccines for Children (VFC)

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. View or print Arkansas Division of Health contact information.

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**. When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **TJ** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables section of this manual. See Part E-F of this section.

E. Billing of Multi-Use and Single-Use Vials

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- Multiple units may be billed when applicable. Take-home drugs are not covered.
 Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - a. Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - b. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - c. Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - d. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

See Section 292.910 for additional information regarding National Drug Code (NDC) billing.

F. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- The <u>first</u> column of the list contains the CPT or HCPCS procedure codes.
- 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 <u>third</u> 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).
- 4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
- 5. The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
- The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)
- The <u>eighth</u> 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. <u>View contact information for the Medical Director for Clinical Affairs</u> <u>for the Division of Medical Services</u>.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9520	No	18y & up	172.0- 175.9	No	No	No	No
A9575	No	2y & up	No	No	No	No	No
A9580*	No	No	View ICD Codes.	No	No	No	No

NOTE: Procedure code A9580 is payable for beneficiaries with a primary diagnosis of (<u>View ICD</u> <u>Codes.</u>). Requires a paper claim with manufacturer's invoice identifying the cost of the radiopharmaceuticals.

A9585	No	2y & up	No	No	No	No	No
A9586	No	18y & up	View ICD Codes.	No	No	No	No
C9132	No	18y & up	286.7	No	Yes	No	No

NOTE: Kcentra is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. Kcentra is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to Kcentra should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9133	No	18y & up	No	No	No	No	No	
C9141	No	6m & up	No	No	No	No	No	
C9248	No	No	No	No	No	No	No	
C9254	No	18y & up	No	No	No	No	No	
C9257*	No	21y & up	Yes	No	Yes	No	Yes	

NOTE: Coverage of procedure code C9257 is for ages 21 years and above with any of these diagnosis codes (View ICD Codes.). Documentation included with Prior Approval Letter request must include Fluoroscein angiogram or OCT, patient screen for conditions that would contraindicate the use of Avastin, and documentation of patient consent.

C9286	No	18y & up	View ICD Codes.	No	No	No	No	
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^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9287*	No	18y & up	View ICD	No	Yes	No	Yes

NOTE: This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multiagent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. Prior approval letter requests should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. The discussion of risk of PML should be documented in medical records.

C9363	No	No	View ICD Codes.	No	No	No	No
C9441	No	18y & up	280.0- 280.9	No	No	No	No
			and				
			285.1		(() .		
			or				
			585.1-				
			585.9				

NOTE: Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia, in adult patients who have intolerance to oral iron, have had an unsatisfactory response to oral iron or who have non-dialysis dependent chronic kidney disease. Patients must have a history and physical exam documenting kidney disease or iron deficiency anemia with intolerance to oral iron. Patients must have lab values showing no increase in iron studies or hemoglobin after administration of oral iron.

J0120	No	No	No	003	No	No	No	
J0129*	No	No	View ICD Codes.	No	No	No	Yes	

NOTE: Patient must have had inadequate response to one or more disease-modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam
showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic
drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis,
etc.

J0133	No	No	View ICD Codes.	No	No	No	No	
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^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0150	No	No	No	No	No	No	No
NOTE: Ma	ximum units	allowed are 4	per day.				
J0151	No	No	No	No	No	No	No
J0171	No	No	No	No	No	No	No
J0178*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.

J0180*	No	No	View ICD Codes.	No	No	No	Yes
NOTE:		code J0180 is w ICD Code	s covered for trea s.).	tment of F	abry's disea	se, with an I	CD diagnosis
J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	No	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: Evaluation by a physician with a specialty in clinical genetics documenting progress required annually.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0221*	No	No	271.0	No	Yes	No	Yes

NOTE: Payable for beneficiaries who have the primary detail diagnosis of late onset, not infantile, Pompe disease. The history and physical by a geneticist showing a diagnosis of late onset, not infantile, Pompe disease must be submitted with the request for the prior approval letter. The beneficiary, physician and infusion center should be enrolled in the Lumizyme 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 FDA. This drug should only be administered in a facility equipped to deal with anaphylaxis, including Advanced Life Support capability.

J0256	No	No	View ICD Codes.	No	No	No	No	
J0257	No	18y & up	View ICD Codes.	No	No	No	No	

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha 1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No
J0280	No	No	No	003	No	No	No
J0285	No	No	No	003	No	No	No
J0287	No	No	No	003	No	No	No
J0288	No	No	No	003	No	No	No
J0289	No	No	No	003	No	No	No
J0290	No	No	No	003	No	No	No
J0295	No	No	No	003	No	No	No
J0300	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0330	No	No	No	003	No	No	No
J0348	No	No	Yes	003	No	No	No
NOTE:	Procedure cod (View ICD Cod transplant state	des.): (1) End-	stage Renal	Disease or (2	2) AIDS or C	Cancer or (3	
J0350	No	No	No	003	No	No	No
J0360	No	No	No	003	No	No	No
J0380	No	No	No	003	No	No	No
J0390	No	No	No	003	No	No	No
J0401	No	13y & up	295 .00- 295.95	No	No	No	No
J0456	No	No	No	003	No	No	No
J0461	No	No	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	View ICD Codes.	No	No	No	No
J0485	No	18y & up	View ICD Codes.	No	No	No	No
J0490	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.

J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is revi	ewed for medi	cal necessity	based on IC	D diagnosis	s code.	
J0586	No	No	No	No	Yes	No	No
NOTE:	This procedure billed.	e code is reviev	wed for medic	cal necessity	based on a	n ICD diag	gnosis code
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD diagno	sis code which	supports me	edical necess	sity is requir	ed.	
J0592	No	No	No	003	No	No	No
J0595	No	No	No	003	No	No	No
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
J0630	No	No	No	003	No	No	No
J0636	No	No	View ICD Codes.	No	No	No	No
J0637*	No	No	No	No	Yes	No	No
NOTE:	Procedure cod who also have physical exam, 30 days of use	a diagnosis of documentation	malignant ne n of failure w	eoplasm or Hith other con	IIV disease. ventional th	Complete erapy and	ory aspergillosis e history and dosage. After
J0638	No	4y &up	View ICD Codes.	No	No	No	No
J0640	No	No	No	003	No	No	No
J0641*	No	No	View ICD Codes.	No	Yes	No	Yes

NOTE: Approved Only:

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

No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
	No No No	No No No No No No	No	No No No 003 No No No 003 No No No 003	No No No 003 No No No No 003 No No No No 003 No	No No No 003 No No No No No 003 No No No No No 003 No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0717*	No	18y & up	555.0- 555.9 or 714.0	No	Yes	No	Yes

NOTE: Prior approval letter requests with clinical documentation are considered for certolizumab pegol (Cimzia) for adult beneficiaries 18 years of age and above with:

- 1. 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 corticosteroids or 6-mercaptopurine/azathioprine.

or

2. For the treatment of moderately-to-severely active rheumatoid arthritis (RA). Patient must have failed **Enbrel** and **Humira**.

No						
140	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
	No No No No No	No	No No No No No No	No No No 003 No No 003	No No No 003 No No No No 003 No	No No No No No No No No No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0770	No	No	No	003	No	No	No
J0780	No	No	No	003	No	No	No
J0795	No	No	No	003	No	No	No
J0800	No	No	No	003	No	No	No
J0833	No	No	No	No	No	No	No
J0834	No	No	No	No	No	No	No
J0850	No	No	No	003	No	No	No



^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881 J0885	No	No	Yes; see below	No	No	No	No

NOTE: For patients on dialysis, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

When the beneficiary is not on dialysis, use ICD-9-CM 285.21.

In addition to the primary diagnosis, an ICD diagnosis code from each column below must be billed on the claim.

Column I	Column	II
	Code	Description
Secondary America (View ICD codes.)	View ICD Codes.	Encounter for antineoplastic chemotherapy
	View ICD Codes.	Following chemotherapy
	View ICD Codes.	Antineoplastic and immunosuppressive drugs

Use ICD code (<u>View ICD Codes.</u>) (primary) with (<u>View ICD Codes.</u>) (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

		Column I		Column	II			
				Code	Description			
		Anemia of other ch disease (<u>View ICD</u> codes.)		View ICD Codes.	Chronic Hepat mention of con			
				View ICD Codes.	Myelodysplast	ic		
				View ICD Codes.	Rheumatoid A	rthritis		
J0882	No	No	View ICD Codes.	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0885							
NOTE: See	e procedure	code J0881 ir	this section	for specific c	riteria.		
J0886	No	No	View ICD Codes.	No	No	No	No
J0894*	No	No	View ICD Codes.	No	No	No	Yes
J0895	No	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (View ICD Codes.). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer (View ICD Codes.) of adjuvant aromatase inhibitor therapy for breast cancer (View ICD Codes.). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

J1267

No

No

protocol).
See Sections 261.000 - 261.220 for prior authorization procedures.
See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	٨	10y & up	٨	No	No	No	No
th	erapeutic use	ed for therape e, a diagnosis g, a FP modifie	and clinical re	ecords must	justify the tr	eatment. V	Vhen billed for
1 re th	1976 and 583 lated to post e allowable f	-58565 service	e family planes during the 65 "procedure	ning services six months for e." All facility	for non-ste ollowing the fees for J1	erile females procedure 050 are bur	des J1050, s only. All visits are included in ndled under the
J1060	No	No	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No
		le J0702 is cov CD Codes.) for					g range of ICD ges.
J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No
14.007	NI-	Ma	NI=	000	No	No	No

003

No

No

No

No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below :

- A valid ICD diagnosis from list 003 or a valid ICD code of the following renal failure code range (View ICD Codes.).
- Plus an ICD diagnosis from the following code range (View ICD Codes.).

Plus an ICD diagnosis of (View ICD Codes.).

J1300	No	No	View ICD Codes.	No	No	No	No
J1320	No	No	No	003	No	No	No
J1325	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1442	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	View ICD Codes.	No	No	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No
J1556*	No	6y & up	279.06	No	Yes	No	Yes

NOTE: **Bivigam** is an immune globulin intravenous solution indicated for the treatment of primary humoral immunodeficiency. For patients at risk for renal dysfunction or thrombotic events, administer at the minimum infusion rate practical. Previous treatments with other agents should be documented. A complete history and physical exam documenting the severity of the illness and prior treatments should be submitted for approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1557	No	2y & up	No	No	Yes	No	No
NOTE: A	n ICD diagno	sis code that s	supports med	ical necessity	is required	i.	
J1559	No	4y & up	View ICD Codes.	No	No	No	No
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE: C	claims are rev	iewed for med	ical necessity	based on th	e ICD diagi	nosis code	billed.
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE: C	claims are rev	iewed for med	ical necessity	based on th	e ICD diagi	nosis code	billed.
J1568	No	No	No	No	Yes	No	No
NOTE: C	claims are rev	iewed for med	ical necessity	based on th	e ICD diagi	nosis code	billed.
J1569	No	No	No	No	Yes	No	No
NOTE: C	claims are rev	iewed for med	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1570	No	No	No	003	No	No	No
J1580	No	No	No	003	No 🔨	No	No
J1590	No	No	No	003	No	No	No
J1599	No	4y & up	No	No	Yes	No	No
NOTE: C	claims are rev	iewed for medi	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1600	No	No	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1602*	No	18y & up	556.0- 556.9	No	Yes	No	Yes
			696.0				
			714.0- 714.9				
			721.9				

NOTE: Simponi is a tumor necrosis factor (TNF) blocker indicated in the treatment of adults with:

- 1. Moderately to severely active rheumatoid arthritis in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 2. Active psoriatic arthritis alone or in combination with methotrexate that has failed **Humira** and **Enbrel**.
- 3. Active ankylosing spondylitis that has failed Humira and Enbrel.
- 4. Moderate to severe ulcerative colitis that has failed Humira.

Medical documentation of physician history and physical exam with records showing failed trial of **Humira** and **Enbrel** as indicated should also be submitted.

J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	View ICD Codes.	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No .	No	003	No	No	No
J1670	No	No	No	003	No	No	No
J1700	No	No	No	003	No	No	No
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1725	No	16y & up	View ICD Codes	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of View ICD codes.), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.

J1745* No No Yes No Yes No Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis code is one of the following: (View ICD Codes.). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

Use an ICD diagnosis code of (<u>View ICD Codes.</u>) as the primary detail diagnosis AND a secondary diagnosis of (View ICD Codes.).

The following ICD diagnosis code (<u>View ICD Codes.</u>) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

J1750	No	No	No	No	No	No	No
J1756*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1786	No	2y & up	View ICD Codes.	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	No	No	003	No	No	No
J1815	No	No	No	003	No	No	No
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	003	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	View ICD Codes.	No	Yes	No	Yes
J1940	No	No	No	003	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No.
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No
J2210	No	No	No	003	No	No	No
J2248	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J2250	No	No	No	003	No	No	No
J2260	No	No	View ICD Codes.	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical sho Prior Approva		se of multiple	sclerosis m	ust be sub	mitted with the
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A F	Prior Approv	al Letter is req	uired for a di	agnosis othe	r than a Lis	003 diagn	osis.
J2355	No	No	No	003	No	No	No
J2358	No	18y & up	No	003	No	No	No
J2360	No	No	No	003	No	No	No
J2370	No	No	No	003	No	No	No
J2400	No	No	No	003	No	No	No
J2405	No	No	No	003	No	No	No
J2410	No	No	No	003	No	No	No
J2425	No	No	No	003	No	No	No
J2426	No	18y & up	View ICD Codes.	No	No	No	No
J2430	No	No	No	003	No	No	No
J2440	No	No	No	003	No	No	No
J2460	No	No	No	003	No	No	No
J2469	No	No	No	003	No	No	No
J2501	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).
See Sections 261.000 - 261.220 for prior authorization procedures.
See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2503	No	No	View ICD Codes.	No	No	No	No
J2504	No	No	View ICD Codes.	No	No	No	No
J2505	No	No	Yes	003	Yes	No	No

NOTE: Procedure code J2505 is payable for beneficiaries of all ages with a detail diagnosis from valid ICD-9-CM diagnosis code ranges 162.0 – 165.9, or 174.0 – 175.9 or 201.00 – 201.98 or 202.80 – 202.88, 288.00-288.04, 288.09 or 288.4 or 288.50-288.51 or 288.59, 289.53, V58.69, V67.51, V58.11, V66.2 and E933.1 are covered along with a diagnosis of AIDS or cancer (List 003). (View ICD Codes.). Diagnosis codes must be shown on the claim form.

J2507*	No	18y & up	View ICD	No	Yes	No	Yes
			274.00				
		•	274.00- 274.03				
			or				
			274.9				

NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.

J2510	No	No	No	003	No	No	No
J2513	No	No	No	No	No	No	No
J2515	No	No	No	003	No	No	No
J2540	No	No	No	003	No	No	No
J2543	No	No	No	003	No	No	No
J2550	No	No	No	003	No	No	No
J2560	No	No	No	003	No	No	No
J2562	No	21y & up	No	No	No	Yes	No

NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the 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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2590	No	No	No	003	No	No	No
J2597	No	No	No	No	No	No	No
J2650	No	No	No	003	No	No	No
J2670	No	No	No	003	No	No	No
J2675	No	No	No	003	No	No	No
J2680	No	No	No	003	No	No	No
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	View ICD Codes.	No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	View ICD Codes.	No	No	No	No

NOTE: 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	View ICD Codes.	No	No	No	No
J2916	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No
J2993	No	No	No	No	No	No	No
		its per day in t				ose of decl	otting
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
		its per day in t ICD diagnosis				ose of decl	otting
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3060*	No	18y & up	272.7	No	Yes	No	Yes
his Th	story and phy	e code is indica ysical exam wi st include the p	th a complete	e evaluation t	y a genetic	ist is requir	red each year.
J3070	No	No	No	003	No	No	No
J3095	No	18y & up	No	003	No	No	No
J3105	No	No	No	003	No	No	No
J3120	No	No	No	003	No	No	No
J3130	No	No	No	003	No	No	No
	No	No	No	003	No	No	No
J3140					Ala	A1-	
J3140 J3150	No	No	No	003	No	No	No
		No No	No No	003	No	No	
J3150	No						No
J3150 J3230	No No	No	No	003	No	No	No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	No	No	003	No	No	No
J3357*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J3385*	No	4y & up	View ICD Codes.	No	Yes	No	Yes
re ar	placement th	ediatric and add nerapy. A histo history and ph symptoms.	ry and physi	cal exam by	a geneticist	is required	yearly for
J3396	No	No	View ICD Codes.	No	Yes	No	No
J3400	No	No	No	003	No	No	No
J3410	No	No	No	003	No	No	No
J3420	No	No	View ICD Codes.	No	No	No	No
J3430	No	No	No	003	No	No	No
J3465	No	No	No	No	No	No	No
NOTE: PI	rocedure cod	e J3465 is cov	ered for non-	pregnant bei	neficiaries.		
J3470	No	No	No	003	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No
J3485	No	No	No	003	No	No	No
J3489	No	No	174.0- 174.9 198.5 203.00- 203.02 203.10- 203.12 203.80- 203.82 275.42 731.0 733.00- 733.09	No	No	No	No

or 733.90

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3490*	U9	16y & up	View ICD	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for "Compounded 17-Hydroxy-progesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.), "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement lee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

		-					
J3520	No	No	No	003	No	No	No
J7178	No	No .	View ICD Codes.	No	No	No	No
J7180	No	2y & up	View ICD Codes.	No	No	No	No
J7183	No	No	View ICD Codes.	No	No	No	No
J7185	No	21y - 65y	No	No	No	No	No
J7186	No	No	No	No	No	No	No
J7187	No	No	No	No	No	No	No
J7190	No	No	No	No	No	No	No
J7191	No	No	No	No	No	No	No
J7192	No	No	No	No	No	No	No
J7193	No	No	No	No	No	No	No
J7194	No	No	No	No	No	No	No
J7195	No	No	No	No	No	No	No
J7196	No	18y & up	View ICD Codes.	No	No	No	No
J7197	No	No	No	No	No	No	No
J7198	No	No	No	No	No	No	No
J7199*	No	No	No	No	No	No	No

NOTE: For consideration, procedure code J7199 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7300	FP	No	No	No	No	No	No
NOTE:	Procedure coophysician. Se	le J7300 requir e Section 292.				n-hospital	based
J7301	FP	10y & up	No	No	No	No	No
NOTE:	Procedure coophysician. See	le J7301 requir e Section 292.				n-hospital I	based
J7302	No	No.	617.0- 617.9 627.2 627.8 or 627.9	No	No	No	No
NOTE:	Covered for the	erapeutic use who have beer		t of heavy me	enstrual ble	eding in wo	men who hav
J7302	FP	No	No	No	No	No	No
NOTE:	Procedure coophysician. See	le J7302 requir e Section 292.				n-hospital l	pased
J7303	FP	No	No	No	No	No	No
NOTE:	Procedure cod physician. Sec					n-hospital I	oased
		0 0000011 202.0					
J7306	FP	No	No	No	No	No	No
	Procedure cod	No	es modifier F	P and is billa	ble by a no		
	Procedure cod	No le J7306 requir	es modifier F	P and is billa	ble by a no		
NOTE: J7307 NOTE:	Procedure cod physician. See	No le J7306 requir e Section 292.8 No le J7307 requir	es modifier F 551 for detaile No es modifier F	P and is billated billing info	No able by a no	n-hospital I	no
NOTE: J7307 NOTE:	Procedure cod physician. See FP Procedure cod	No le J7306 requir e Section 292.8 No le J7307 requir	es modifier F 551 for detaile No es modifier F	P and is billated billing info	No able by a no	n-hospital I	no

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7312*	No	18y & up	View ICD Codes. 362.20	No	Yes	No	Yes
			362.30				
			362.35				
			362.36				
			363.20				

NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method.

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.

J7316*	No	18y & up	379.27	No	Yes	No	Yes

NOTE: **Jetrea** is a proteolytic enzyme indicated for the treatment of symptomatic vitreomacular adhesion. Immediately following the injection the patient must be monitored for elevation in intraocular pressure. The dose, lot number and manufacturer must be documented. A complete history and physical with visual exam including visual acuity must be submitted with the request for a prior approval letter.

J7321	No	No	No	No	No	Yes	No
J7323	No	No	No	No	No No		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 **Hyaluronon** injection in the physician's office 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. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 261.200 for Utilization Review prior authorization information. The request must include the patient's name, Medicaid ID number, physician's 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. Refer to Section 261.200 for Prior Authorization.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7330	No	No	No	No	No	Yes	No
	Procedure cod Sections 260.0				n AFMC for	all providers	s. See
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No
J7508	No	No	V42.0 V42.89	No	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
J7513	No	No	No	003	No	No	No
J7515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No
J7520	No	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No	No
	For considerati					er claim form	with the
J7527	No	18y & up	View ICD Codes.	No	No	No	No
J7599*	No	No	No	No	No	No	No
	For considerati					er claim form	with the
J8530	No	No	No	003	No	No	No
J8650*	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
J9000	No	No	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9017	No	No	No	003	No	No	No
J9019*	No	2y - 18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	View ICD Codes.	No	Yes	No	Yes
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9035*	No	No	View ICD Codes.	No	Yes	No	Yes
J9040	No	No	No	003	No	No	No
J9041*	No	No	View ICD Codes.	No	Yes	No	Yes
J9042*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma diagnosis (View ICD Codes.) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J9043* No 18y & up <u>View ICD</u> No Yes No Yes Codes.

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9045	No	No	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9047*	No	18y & up	203.00-	No	Yes	No	Yes

NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.

J9050	No	No	No	003	No	No	No
J9055*	No	No	View ICD Codes.	No	Yes	No	Yes
J9060	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9098	No	No	No	003	No	No	No
J9100	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9155	No	21y & up	No	003	No	No	No
J9160	No	No	View ICD Codes.	No	Yes	No	Yes
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	View ICD Codes.	003	Yes	No	Yes
J9179*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

J9181	No	No	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9185	No	No	No	003	No	No	No
J9190	No	No	No	003	No	No	No
J9200	No	No	No	003	No	No	No
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	View ICD Codes.	No	No	No	No
NOTE: Fo	r male bene	ficiaries of all a	ages. Benefi	t limit is one p	orocedure e	very 12 mo	onths.
J9225	No	No	View ICD Codes.	No	No	No	No
J9226*	No	0 - 12y	View ICD Codes.	No	Yes	No	Yes

NOTE: Supprelin LA: Prior to initiation of treatment, a clinical diagnosis of CPP (View ICD Codes.) should be confirmed by measurement of blood concentrations of total sex steroids, luteinizing hormone (LH) and follicle stimulating hormone (FSH) following stimulation with a GnRH analog, and assessment of bone age versus chronological age. Baseline evaluations should include height and weight measurements, diagnostic imaging of the brain (to rule out intracranial tumor), pelvic/testicular/adrenal ultrasound (to rule out steroid secreting tumors), human chorionic gonadotropin levels (to rule out a chorionic gonadotropin secreting tumor) and adrenal steroids to exclude congenital adrenal hyperplasia. All tests and screenings must be documented by medical records and submitted with history and physical examination when requesting prior approval.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9228*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: **Ipilmumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	View ICD Codes.	No	Yes	No	Yes

NOTE: The disease must have not responded to or has relapsed following treatment with at least 2 chemotherapy regimens.

								_
J9262*	No	18y & up	205.10- 205.12	No	Yes	No	Yes	
J9262*	No	18y & up	205.10- 205.12	No	Yes	No	Yes	

NOTE: **Synribo** is indicated for treatment of adult patients with chronic or accelerated chronic myeloid leukemia with resistance and/or tolerance to two or more tyrosine inhibitors. A history and physical exam documenting previous treatment should be submitted with the request for a prior approval letter.

J9263*	No	No	View ICD Codes.	No	Yes	No	Yes
J9264*	No	No	View ICD Codes.	No	Yes	No	Yes
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9293	No	No	Yes	No	Yes	No	No
NOTE: Red	quires ICD	diagnosis code	for cancer o	r ICD diagno	sis code of	(View ICD	Codes.).
J9300	No	No	No	003	No	No	No
J9303*	No	No	View ICD Codes.	No	Yes	No	Yes
J9305*	No	No	View ICD Codes.	No	Yes	No	Yes
J9306*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Perjeta** is an agent for the treatment of adults, age 18-99 years old, that is a Her2/neu receptor antagonist indicated in combination with trastuzumab and docetaxol for the treatment of patients with Her2-positive metastatic breast cancer who have not received prior anti-Her2 therapy or chemotherapy for metastatic disease. A physician history and physical exam documenting all previous treatment should be included. All Federal Drug Administration warnings and precautions should be followed.

J9307	No	18y & up	No	003	No	No	No
J9310	No	No	No	003	No	No	No
J9315	No	18y & up	No	003	No	No	No
J9320	No	No	No	003	No	No	No
J9328*	No	21y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: The diagnosis must be for:

 Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	View ICD Codes.	No	No	No	No	
J9340	No	No	No	003	No	No	No	
J9351	No	18y & up	No	003	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9354*	No	18y & up	174.0- 175.9	No	Yes	No	Yes

NOTE: **Kadcyla** is a Her2-targeted antibody and microtubule inhibitor conjugate indicated, as a single agent, for the treatment of adults with Her2-positive, metastatic breast cancer, who previously received **trastuzumab** and a **taxane**, separately or in combination. Patients should have either:

1. received prior therapy for metastatic disease,

or

2. developed disease recurrence during or within six months of completing adjuvant therapy.

All of the above requirements should be documented in a history and physical exam included in the request. All prior treatments should be listed. Approval will be on a case-by-case basis.

J9355	No	No	No	003	No	No	No
J9357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No
J9371*	No	18y & up	204.00- 204.02	No	Yes	No	Yes

NOTE: Marqibo is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.

J9390	No	No	No	003	No	No	No
J9395*	No	No	View ICD Codes.	No	Yes	No	Yes
J9400*	No	18y & up	153.0- 154.8	No	Yes	No	Yes

NOTE: This procedure code is indicated in adults with a diagnosis of metastatic colorectal cancer (mCRC), that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam documenting stage of cancer and all regimens that the patient has been on should be sent.

10000				000			
J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No
NOTE:	See Section	292.950 B fo	or coverage in	nformation.			
P9041	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ire Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
P9045	No	No	No	No	No	No	No
P9046	No	No	No	No	No	No	No
P9047	No	No	No	No	No	No	No
Q0139	No	No	View ICD Codes.	No	No	No	No
Q0162	UB	4y & up	No	No	No	No	No
NOTE:	QO162-UB rep	resents "Onda	ansetron 1 mg	g, oral" billab	le electronic	ally or on p	paper.
Q0166	UB	No	No	003	No	No	No
NOTE:	Use UB modific Medicaid descri		"Granistron I	HCI tab1mg,	oral" (Kytril). This is t	he Arkansas
Q2009	No	No	No	003	No	No	No
Q2017	No	No	No	003	No	No	No
Q2034	No	18y & up	No	No	No	No	No
Q2043*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.

Q2049	No	18y & up	No	003	No	No	No
Q2050	No	No	No	003	No	No	No
Q3027	No	18y & up	340	No	No	No	No
Q4081	No	No	View ICD Codes.	No	No	No	No
Q4121	No	No	No	No	No	No	No
Q4124	No	No	No	No	No	No	No
Q4141*	No	No	No	No	No	No	No
NOTE:	Must be bille	ed with manufac	turer's invoice	e attached			
Q4145*	No	No	No	No	No	No	No
NOTE:	Must be bille	ed with manufac	turer's invoice	e attached			
Q9969	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
S0032	No	No	No	003	No	No	No
S0034	No	No	No	003	No	No	No
S0039	No	No	No	003	No	No	No
S0040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
S0077	No	No	No	003	No	No	No
S0080	No	No	No	003	No	No	No
S0081	No	No	No	003	No	No	No
S0092	No	No	No	003	No	No	No
S0093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
S0119	No	4y & up	No	No	No	No	No
S0145	No	No	View ICD Codes.	No	No	No	No
S0164	No	No	No	003	No	No	No
S0177	No	No	No	003	No	No	No
S0179	No	No	No	003	No	No	No
S0187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No
NOTE: Pro	cedure cod	e Z1847 is for	Torecan 10	mg oral table	ts. Limit of	(4) 10 mg t	abs per day.
90284	No	No	No	No	Yes	No	No
NOTE: 9028	34 will be ap	proved for payr	nent based o	n diagnosis co	ode that prov	ves medical	necessity.
90375*	No	No	No	No	No	No	No
be dos	attached ald	ervice must be ong with the cli mical site and l fee.	nical adminis	stration recor	ds indicating	g medical n	ecessity,

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures.
See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90376*	No	No	No	No	No	No	No
	be attached al	service must be long with the cli mical site and fee.	inical adminis	stration recor	ds indicating	g medical r	necessity,
90385	No	No	No	No	No	No	No
NOTE:	Procedure cod	de 90385 is limi	ted to one in	jection per pr	egnancy.		
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose	and attach mar	nufacturer's in	nvoice.			
90632	No	19y & up	No	No	No	No	No
90633	EP, TJ	1y – 18y	No	No	No	No	No
90633	TJ	0 – 18y	No	No	No	No	No
90634	EP, TJ	1y - 18y	No	No	No	No	No
90634	TJ	1y - 18y	No	No	No	No	No
90636	EP, TJ	18y	No	No	No	No	No
90636	TJ	18y	No	No	No	No	No
90636	No	19y & up	No	No	No	No	No
90645	EP, TJ	0 - 18y	No	No	No	No	No
90645	TJ	0 - 18y	No	No	No	No	No
90645	No	19y & up	No	No	No	No	No
90646	EP, TJ	0 - 18y	No	No	No	No	No
90646	TJ	0 - 18y	No	No	No	No	No
90646	No	19y & up	No	No	No	No	No
90647	EP, TJ	0 - 18y	No	No	No	No	No
90647	TJ	0 - 18y	No	No	No	No	No
90647	No	19y & up	No	No	No	No	No
90648	EP, TJ	0 - 18y	No	No	No	No	No
90648	TJ	0 - 18y	No	No	No	No	No
90649	EP, TJ	9y - 18y	No	No	No	No	No
90649	TJ	9y - 18y	No	No	No	No	No
90650	EP, TJ	9y - 18y	No	No	No	No	No
90650	TJ	9y - 18y	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures. See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifie	er Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90654	EP, TJ	18y-18y	No	No	No	No	No
		ure is billable for f this section for a			re not pregr	nant. See S	Subsections A
90654	TJ	18y-18y	No	No	No	No	No
		ure is billable for f this section for a			re not pregr	nant. See S	Subsections A
0654	No	19y - 64y	No	No	No	No	No
		ure is billable for f this section for a			re not pregr	nant. See S	Subsections A
0655	EP, TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subsec	tions A through	of this section	on for additio	nal instruct	ions.	
0655	TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subsec	tions A through D	of this section	on for additio	nal instruct	ions.	
0656	EP, TJ	3y - 18y	No	No	No	No	No
NOTE:	See Subsec	tions A through D	of this section	on for addition	nal instruct	ions.	
90656	TJ	3y - 18y	No	No	No	No	No
NOTE:	See Subsec	tions A through E	of this section	on for additio	nal instruct	ions.	
0656	No	19y & up	No	No	No	No	No
NOTE:	See Subsec	tions A through E	of this section	on for additio	nal instruct	ions.	
0657	EP, TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subsec	tions A through E	of this section	on for additio	nal instruct	ions.	
0657	TJ	6m - 35m	No	No	No	No	No
NOTE:	See Subsec	tions A through D	of this section	on for additio	nal instruct	ions.	
0657	No	19y & up	No	No	No	No	No
NOTE:	See Subsec	tions A through D	of this section	on for additio	nal instruct	ions.	
0658	EP, TJ	3y - 18y	No	No	No	No	No
NOTE:	See Subsec	tions A through D	of this section	on for additio	nal instruct	ions.	
0658	TJ	3y – 18y	No	No	No	No	No
OTE:	See Subsec	tions A through D	of this section	on for additio	nal instructi	ions.	
0658	No	19y & up	No	No	No	No	No
OTE:	See Subsec	tions A through D	of this section	on for additio	nal instructi	ions.	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter	
90660	EP, TJ	2y – 18y	No	No	No	No	No	
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A	
90660	TJ	2y – 18y	No	No	No	No	No	
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A	
90660	No	19y - 49y	No	No	No	No	No	
NOTE:	This procedure through D of th				re not pregr	nant. See S	Subsections A	
90662	No	65y & up	No	No	No	No	No	
90669	EP, TJ	0 – 5y	No	No	No	No	No	
90669	TJ	0 – 5y	No	No	No	No	No	
90670	EP, TJ	0 – 5y	No	No	No	No	No	
90670	TJ	0 – 5y	No	No	No	No	No	
90672	EP, TJ	2y – 18y	No	No	No	No	No	
NOTE:	This procedure through D of th				e not pregr	nant. See S	Subsections A	
90672	TJ	2y – 18y	No	No	No	No	No	
NOTE:	This procedure is billable for healthy individuals who are not pregnant. See Subsections A through D of this section for additional instructions.							
90672	No	19y – 49y	No	No	No	No	No	
NOTE:	This procedure through D of the				re not pregr	nant. See S	Subsections A	
90673	EP, TJ	18y	No	No	No	No	No	
90673	TJ	18y	No	No	No	No	No	
90673	No	19y - 49y	No	No	No	No	No	
90675*	No	No	No	No	No	No	No	
NOTE:	Procedure coopaper claims we for each date of indicated and must be attach	vith procedure of service. If d must be identif	code and dos ate spans are ied for each	sage entered e used, appro date within th	in Field 24 opriate units ne span. Th	D of claim f of service e manufact	orm CMS-150 must be	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter		
90676*	No	No	No	No	No	No	No		
NOTE:	paper claims was for each date of indicated and	de 90676 is cov with procedure of service. If da must be identif ned. Reimburs	code and dos ate spans are ied for each o	sage entered used, approdate within th	in Field 24 priate units e span. Th	D of claim f of service e manufact	orm CMS-1500 must be		
90680	EP, TJ	6w - 32w	No	No	No	No	No		
90680	TJ	6w - 32w	No	No	No	No	No		
90681	EP, TJ	6w - 32w	No	No	No	No	No		
90681	TJ	6w - 32w	No	No	No	No	No		
90685	EP, TJ	6m – 35m	No	No	No	No	No		
NOTE:	See Subsection	ons A through	of this section	on for additio	nal instructi	ions.			
90685	TJ	6m – 35m	No	No	No	No	No		
NOTE:	See Subsection	ons A through D	of this section	on for additio	nal instructi	ions.			
90686	EP, TJ	3y – 18y	No	No	No	No	No		
		e is billable for his section for a			re not pregn	ant. See S	Subsections A		
90686	TJ	3y – 18y	No	No	No	No	No		
		e is billable for a			e not pregn	ant. See S	Subsections A		
90686	No	19y – 99y	No	No	No	No	No		
		e is billable for la			e not pregn	ant. See S	Subsections A		
90688	EP, TJ	3y - 18y	No	No	No	No	No		
		e is billable for lands			e not pregn	ant. See S	Subsections A		
90688	TJ	3y - 18y	No	No	No	No	No		
	This procedure is billable for healthy individuals who are not pregnant. See Subsections A through D of this section for additional instructions.								
90688	No	19y & up	No	No	No	No	No		
	This procedure is billable for healthy individuals who are not pregnant. See Subsections A through D of this section for additional instructions.								
90690	No	6y & up	No	No	No	No	No		
90691	No	3y & up	No	No	No	No	No		

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90692	No	No	No	No	No	No	No
90696	EP, TJ	4y – 6y	No	No	No	No	No
90696	TJ	4y – 6y	No	No	No	No	No
90698	EP, TJ	0 – 4y	No	No	No	No	No
90698	TJ	0 – 4y	No	No	No	No	No
90700	EP, TJ	0 – 6y	No	No	No	No	No
90700	TJ	0 - 6y	No	No	No	No	No
90702	EP, TJ	0 – 6y	No	No	No	No	No
90702	TJ	0 - 6 y	No	No	No	No	No
90703	No	No	No	No	No	No	No
90704	No	1y & up	No	No	No	No	No
90705	No	9m & up	No	No	No	No	No
90706	No	1y & up	No	No	No	No	No
90707	U1	21y - 44y	No	No	No	No	No

NOTE: Procedure code 90707 is payable when provided to women of childbearing age, ages 21 through 44, who may be at risk of exposure to these diseases. Coverage is limited to two (2) injections per lifetime. U1 modifier is required for this age group.

90707	EP, TJ	0 – 18y	No	No	No	No	No	
90707	TJ	0 – 18y	No	No	No	No	No	
90707	No	19y – 20y	No	No	No	No	No	
90708	No	0 - 99y	No	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90710	EP, TJ	0 – 18y	No	No	No	No	No
90710	TJ	0 – 18y	No	No	No	No	No
90710	No	0 – 20y	No	No	No	No	No
90712	No	0 – 20y	No	No	No	No	No
90713	EP, TJ	0 – 18y	No	No	No	No	No
90713	TJ	0-18y	No	No	No	No	No
90713	No	19y & up	No	No	No	No	No
90714	EP, TJ	7y – 18y	No	No	No	No	No
90714	TJ	7y ~ 18y	No	No	No	No	No
90714	No	19y & up	No	No	No	No	No
90715	EP, TJ	7y – 18y	No	No	No	No	No
90715	TJ	7y – 18y	No	No	No	No	No
90715	No	19y & up	No	No	No	No	No
90716	EP, TJ	0 – 18y	No	No	No	No	No
90716	TJ	0 – 18y	No	No	No	No	No
90716	No	0 – 20y	No	No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: S	ubmit invoice	with claim.					
90719	No	No	No	No	No	No	No
90720	EP, TJ	0 - 18y	No	No	No	No	No
90720	TJ	0 - 18y	No	No	No	No	No
90720	No	0 - 20y	No	No	No	No	No
90721	EP, TJ	0 - 18y	No	No	No	No	No
90721	TJ	0 - 18y	No	No	No	No	No
90721	No	1y - 20y	No	No	No	No	No
90723	EP, TJ	0 - 18y	No	No	No	No	No
90723	TJ	0 - 18y	No	No	No	No	No
90725*	No	No	No	No	No	No	No
NOTE: S	ubmit manufa	cturer's invoice	e.				
90727*	No	No	No	No	No	No	No
		cturer's invoice					

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
90732	EP, TJ	2y – 18y	No	No	No	No	No
90732	TJ	2y – 18y	No	No	No	No	No
90732	No	2y & up	No	No	No	No	No
		1 years and old th risk. All ben					
90733	No	No	No	No	No	No	No
90734	EP, TJ	0 - 18y	No	No	No	No	No
90734	TJ	0 - 18y	No	No	No	No	No
90734	No	19y & up	No	No	No	No	No
90735	No	0 - 20y	No	No	No	No	No
90736	No	60y & up	No	No	No	No	No
NOTE: Z	Zoster vaccine	is benefit limit	ted to once in	a lifetime.			
90740	No	No	No	No	No	No	No
90743	EP, TJ	0 - 18y	No	N6	No	No	No
90743	TJ	0 - 18y	No	No	No	No	No
90744	EP, TJ	0 - 18y	No	No	No	No	No
90744	TJ	0 - 18y	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
90747	EP, TJ	0 - 18y	No	No	No	No	No
90747	TJ	0 - 18y	No	No	No	Nø	No
90747	No	19y & up	No	No	No	No	No
90748	EP, TJ	0 - 18y	No	No	No	No	No
90748	TJ	0 - 18y	No	No	No	No	No
90748	No	19y & up	No	No	No	No	No
90749*	No	No	No	No	No	No	No
p	provided (drug	r procedure co , dose, route o uding docume	f administrati	ion) as well a	s clinical no		
96379*	No	No	No	No	No	No	No
þ	provided (drug	r procedure co , dose, route o uding docume	f administrati	ion) as well a	s clinical no		

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

A. Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379 and 96401 through 96549 for therapeutic and chemotherapy administration procedure codes.

See Section 292.940 for radiopharmaceutical drugs.

- B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:
 - The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
 - Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
 - 3. All other billing requirements must be met in order for payment to be approved.

C. Immunizations

Physicians may bill for immunization procedures on the CMS-1500 claim form. View a CMS-1500 sample form. See Sections 292.920, 292.930 and 292.950 for covered vaccines and billing protocols.

D. Tables of Payable Procedure Codes

The tables of payable procedure codes are designed with eight columns of information.

- 1. The first column of the list contains the CPT or HCPCS procedure codes.
- The <u>second</u> column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
- 3. The <u>third</u> 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).
- 4. The fourth column indicates specific ICD primary diagnosis restrictions.
- 5. The <u>fifth</u> column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
- The <u>sixth</u> column indicates whether a procedure is subject to medical review before payment.
- 7. The <u>seventh</u> column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)
- 8. 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. Medical Director for Clinical Affairs for the Division of Medical Services.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
A9580*	No	No	View ICD Codes.	No	No	No	No
	Procedure cod Codes.). Requadiopharmace	uires a paper d	yable for ben claim with ma	eficiaries with nufacturer's	n a primary invoice ider	diagnosis on tifying the o	of (View ICD cost of the
A9585	No	2y & up	No	No	No	No	No
A9586	No	18y & up	View ICD Codes.	No	No	No	No
C8931	No	No	No	No	No	No	No
C8932	No	No	No	No	No	No	No
C8934	No	No	No	No	No	No	No
C8935	No	No	No	No	No	No	No
C8936	No	No	No	No	No	No	No
C9141	No	6m & up	No	No	No	No	No
C9248	No	No	No	No	No	No	No
C9254	No	18y & up	No	No	No	No	No
C9257*	No	21y & up	Yes	No	Yes	No	Yes
	Coverage of pr diagnosis code request must in would contrain	es (<u>View ICD C</u> nclude Fluoros	cein angiogra	cumentation i am or OCT, p	ncluded wit patient scre	Prior App en for condi	roval Letter itions that
C9286	No	18y & up	View ICD Codes.	No	No	No	No

 C9286
 No
 18y & up
 View ICD Codes.
 No
 No
 No
 No

 C9287*
 No
 18y & up
 View ICD Codes.
 No
 Yes
 No
 Yes

NOTE: This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multiagent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. Prior approval letter requests should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. The discussion of risk of PML should be documented in medical records.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9292	No	18y & up	View ICD Codes.	No	No	No	No
C9294*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: A complete medical exam with history is required and must be submitted with a yearly evaluation by a geneticist. Prognosis should be documented as well as all prior treatments. If prior treatment is implucerase, the dose and outcome of treatment should be included.

C9295	No	18y & up Viet	w ICD No les.	No	No	No	
C9296*	No	18y & up Viet	w ICD No	Yes	No	Yes	

NOTE: This procedure code is used in combination with 5-fluorouracil, leucovorin and irinotecan (FOLFIRI) in patients with metastatic colorectal cancer (mCRC) that is resistant to or has progressed following an oxaliplatin-containing regimen. A complete history and physical exam must be sent with all previous treatments noted. Hemorrhage, gastrointestinal perforation and compromised wound healing are all complications of this procedure code and should be evaluated.

C9363	No	No	View ICD Codes.	No	No	No	No
C9733	No	No	No	No	No	No	No
J0120	No	No	No	003	No	No	No
J0129*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: Patient must have had inadequate response to one or more disease modifying antirheumatic drugs such as **Methotrexate** or Tumor Necrosis Factor antagonists (**Humira**, **Remicade**, etc.). Records submitted with claim must include history and physical exam
showing severity of rheumatoid arthritis, treatment with disease-modifying anti-rheumatic
drugs and treatment failure resulting in progression of joint destruction, swelling, tendonitis,
etc.

No	No	View ICD Codes.	No	No	No	No
No	No	No	No	No	No	No
Maximum u	nits allowed a	are 4 per day.				
No	No	No	No	No	No	No
	No Maximum ui	No No Maximum units allowed a	No No No Maximum units allowed are 4 per day.	No No No No Maximum units allowed are 4 per day.	No No No No No Maximum units allowed are 4 per day.	No No No No No No Maximum units allowed are 4 per day.

NOTE: When administered in the office, the provider must have nursing staff available to monitor the patient's vital signs during infusion. The provider must be able to treat cardiac shock and to provide advanced cardiac life support in the treatment area where the drug is infused. Can be billed electronically or on paper. Maximum units 1 per day.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

J0256

No

No

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0171	No	No	No	No	No	No	No
J0178*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Eylea should only be administered by a retinal specialist or other physician trained in retinal care. Contraindicated in ocular or periocular infections, active intraocular inflammation and hypersensitivity. Intravitreal injections have been associated with endophthalmitis and retinal detachments. Patients should be instructed to report any symptoms as soon as possible. Patients should be monitored for 60 minutes after injection due to acute increases in intraocular pressure seen with Eylea injections. There is a potential risk of arterial thromboembolic events following use of this class of drugs. Patients should be screened for risk factors of stroke, myocardial infarction or vascular events. Submit screening history to the Medical Director for Clinical Affairs as well as OCT or fluorescein angiogram to evaluate lesion type, location and size and presence of subretinal fluid. The medical record must contain the actual dosage, site, lot number of the vial, date and time of administration and any unusual reactions. All of this must be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter.

	Affairs for a	Prior Approv	al letter.				
J0180*	No	No	View ICD Codes.	No	No	No	Yes
NOTE:		ode J0180 is w ICD Code	covered for treas.).	tment of F	abry's disea	ise, with an IC	CD diagnosis
J0190	No	No	No	003	No	No	No
J0205	No	No	No	003	Nø	No	No
J0207	No	No	No	003	No	No	No
J0210	No	No	No	003	No	No	No
J0220*	No	No	View ICD Codes.	No	No	No	Yes
NOTE:	Evaluation bannually.	y a physiciai	n with a specialty	in clinical	l genetics do	cumenting pr	ogress require

No

No

No

No

View ICD

Codes.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0257	No	18y & up	View ICD Codes.	No	No	No	No

NOTE: This drug or other drugs in this class are only approved for the diagnosis of alpha 1proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1proteinase must be clearly documented in the chart. Alpha 1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of the therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha 1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency-associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha 1 antitrypsin levels above 80 mg/dl. Due to risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.

J0278	No	No	No	003	No	No	No
J0280	No	No	No	003	No	No	No
J0285	No	No	No	003	No	No	No
J0287	No	No	No	003	No	No	No
J0288	No	No	No	003	No	No	No
J0289	No	No	No	003	No	No	No
J0290	No	No	No	003	No	No	No
J0295	No	No	No	003	No	No	No
J0300	No	No	No	003	No	No	No
J0330	No .	No	No	003	No	No	No
J0348	No	No	Yes	003	No	No	No

NOTE: Procedure code J0348 is valid for any condition below, along with an ICD diagnosis code of (<u>View ICD Codes.</u>): (1) End-stage Renal Disease or (2) AIDS or Cancer or (3) Post transplant status or specify transplanted organ and transplant date.

No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
No	No	No	003	No	No	No
	No No No	No No No No No No	No	No No No 003 No No No 003 No No No 003	No No No 003 No No No No 003 No No No No 003 No	No No No No No No No No 003 No No No No No 003 No No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0461	No	No	No	003	No	No	No
J0470	No	No	No	003	No	No	No
J0475	No	No	No	No	No	No	No
J0476	No	No	No	No	No	No	No
J0480	No	No	View ICD Codes.	No	No	No	No
J0485	No	18y & up	View ICD Codes.	No	No	No	No
J0490	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a theumatologist.

J0500	No	No	No	003	No	No	No
J0515	No	No	No	003	No	No	No
J0520	'No	No	No	003	No	No	No
J0558	No	No	No	003	No	No	No
J0561	No	No	No	003	No	No	No
J0585	No	No	No	No	Yes	No	No
NOTE:	Botox A is re	eviewed for med	dical neces	sity based on	ICD diagnos	sis code.	
J0586	No	No	No	No	Yes	No	No
NOTE:	This proced billed.	ure code is revi	ewed for m	nedical necess	sity based on	an ICD diag	nosis code
J0588	No	18y & up	No	No	Yes	No	No
NOTE:	An ICD diag	nosis code which	ch supports	s medical nec	essity is requ	ired.	
J0592	No	No	No	003	No	No	No
J0595	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0597*	No	13y & up	View ICD Codes.	No	No	No	No
	This code will bubmitted.	pe reviewed fo	r medical ned	cessity based	on the clin	ical docum	entation
J0600	No	No	No	003	No	No	No
J0610	No	No	No	003	No	No	No
J0620	No	No	No	003	No	No	No
J0630	No	No	No	003	No	No	No
J0636	No	No	View ICD Codes.	No	No	No	No
J0637*	No	No	No	No	Yes	No	No
V	vho also have physical exam,	e J0637 is cov a diagnosis of documentatio , an updated m	malignant ne n of failure w	eoplasm or H with other con-	IV disease. ventional th	Complete erapy and	history and
J0638	No	4y &up	View ICD Codes.	No	No	No	No
J0640	No	No	No	003	No	No	No
J0641*	No	No	View ICD Codes.	No	Yes	No	Yes
NOTE: A	Approved Onl	v:			\/		

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

J0670	No	No	No	003	No	No	No
J0690	No	No	No	003	No	No	No
J0692	No	No	No	003	No	No	No
J0694	No	No	No	003	No	No	No
J0696	No	No	No	003	No	No	No
J0697	No	No	No	003	No	No	No
J0698	No	No	No	003	No	No	No
J0702	No	No	Yes	003	No	No	No

NOTE: Procedure code J0702 is covered for a valid diagnosis code (View ICD Codes.) for complications of pregnancy or List 003 for all ages.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0706	No	No	No	003	No	No	No
J0710	No	No	No	003	No	No	No
J0712	No	18y & up	No	No	No	No	No
J0713	No	No	No	003	No	No	No
J0715	No	No	No	003	No	No	No
J0716	No	No	View ICD Codes.	No	No	No	No



See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0718*	No	18y & up	No	No	Yes	No	Yes

NOTE: 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 pair
- 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

o 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.

J0720	No	No	No	003	No	No	No
J0725	No	No	No	003	No	No	No
J0735	No	No	No	003	No	No	No
J0740	No	No	No	003	No	No	No
J0743	No	No	No	003	No	No	No
J0744	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0881 J0885	No	No	Yes; see below	No	No	No	No

NOTE: For all diagnoses, use the lowest dose that will gradually increase the Hgb concentration to the lowest level sufficient to avoid the need for a red blood cell transfusion.

In addition to the primary diagnosis, an ICD diagnosis code from each column below must be billed on the claim.

Column	Column	II
	Code	Description
Secondary Anemia (View ICD codes.)	View ICD Codes.	Encounter for antineoplastic chemotherapy
	View ICD Codes.	Following chemotherapy
	View ICD Codes	Antineoplastic and immunosuppressive drugs

Use ICD code (<u>View ICD Codes.</u>) (primary) with (<u>View ICD Codes.</u>) (secondary) to represent patients with anemia due to hepatitis C (patients being treated with ribavirin and interferon alfa or ribavirin and peginterferon alfa), myelodysplastic syndrome or rheumatoid arthritis.

		Column I		Column	II		
				Code	Description		
		Anemia of othe disease (View codes.)		View ICD Codes.	Chronic Hep mention of o	t	
				View ICD Codes.	Myelodyspla		
				View ICD Codes.	Rheumatoid	Arthritis	
J0882	No	No	View ICD Codes.	No	No	No	No
10885							

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	ıre Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
NOTE:	See procedure	e code J0881 ir	n this section	for specific o	riteria.		
J0886	No	No	View ICD Codes.	No	No	No	No
J0894*	No	No	View ICD Codes.	No	No	No	Yes
J0895	No	No	No	No	No	No	No
J0897*	No	18y & up	Yes	No	Yes	No	Yes

NOTE: Prolia Policy: Covered for female, post-menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (View ICD Codes.). 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. An additional indication approved by the FDA for use of Prolia is as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer (View ICD Codes.) or adjuvant aromatase inhibitor therapy for breast cancer (View ICD Codes.). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request

Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 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. The NDC for the drug requested must be listed on the request.

J0900	No	No	No	003	No	No	No
J0945	No	No	No	003	No	No	No
J1000	No	No	No	003	No	No	No
J1020	No	No	No	003	No	No	No
J1030	No	No	No	003	No	No	No
J1040	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

No

No

J1267

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1050	٨	10y & up	٨	No	No	No	No
t	J1050 is cover therapeutic use family planning	e, a diagnosis	and clinical re	ecords must	justify the tr	eatment. \	When billed for
r t	related to post-	301 are payabl -58565 service se for the 5850	e family planes s during the 55 "procedure	ning services six months fo e." All facility	for non-ste ollowing the fees for J1	erile female procedure 050 are bu	odes J1050, s only. All visit are included ir ndled under the
J1060	No	No	No	003	No	No	No
J1070	No	No	No	003	No	No	No
J1080	No	No	No	003	No	No	No
J1094	No	No	No	003	No	No	No
J1100	No	No	Yes	003	No	No	No
	Procedure cod codes (View IC						ng range of ICD ges.
J1110	No	No	No	003	No	No	No
J1120	No	No	No	003	No	No	No
J1160	No	No	No	003	No	No	No
J1165	No	No	No	003	No	No	No
J1170	No	No	No	003	No	No	No
J1180	No	No	No	003	No	No	No
J1190	No	No	No	003	No	No	No
J1200	No	No	No	003	No	No	No
J1205	No	No	No	003	No	No	No
J1212	No	No	No	003	No	No	No
J1230	No	No	No	003	No	No	No
J1240	No	No	No	003	No	No	No
J1245	No	No	No	003	No	No	No
J1250	No	No	No	003	No	No	No
J1260	No	No	No	003	No	No	No

No

003

No

No

No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1270	No	No	Yes	003	No	No	No

NOTE: Procedure code J1270 is payable for beneficiaries with a minimum of three diagnoses codes from the listing below:

- A valid ICD diagnosis from list 003 or a valid ICD code of the following renal failure code range (View ICD Codes.).
- Plus an ICD diagnosis from the following code range (View ICD Codes.).

Plus an ICD diagnosis of (View ICD Codes.).

J1300	No	No	View ICD Codes.	No	No	No	No
J1320	No	No	No	003	No	No	No
J1325	No	No	No	003	No	No	No
J1330	No	No	No	003	No	No	No
J1335	No	No	No	003	No	No	No
J1364	No	No	No	003	No	No	No
J1380	No	No	No	003	No	No	No
J1410	No	No	No	003	No	No	No
J1435	No	No	No	003	No	No	No
J1436	No	No	No	003	No	No	No
J1440	No	No	No	No	No	No	No
J1441	No	No	No	No	No	No	No
J1450	No	No	No	003	No	No	No
J1452	No	No	No	003	No	No	No
J1453	No	No	No	003	No	No	No
J1455	No	No	No	003	No	No	No
J1457	No	No	No	003	No	No	No
J1458*	No	No	View ICD Codes.	No	No	No	Yes
J1459	No	16y & up	No	No	No	No	No
J1460	No	No	No	No	No	No	No
J1557	No	2y & up	No	No	Yes	No	No
NOTE: A	An ICD diag	nosis code that	supports med	ical neces	ssity is requir	ed.	
J1559	No	4y & up	View ICD Codes.	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedur Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE: (Claims are rev	iewed for med	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE: (Claims are rev	iewed for med	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1568	No	No	No	No	Yes	No	No
NOTE: (Claims are rev	iewed for med	ical necessity	based on th	e ICD diagr	nosis code	billed.
J1569	No	No	No	No	Yes	No	No
NOTE: (Claims are rev	iewed for med	cal necessity	based on th	e ICD diagr	nosis code	billed.
J1570	No	No	No	003	No	No	No
J1580	No	No	No	003	No	No	No
J1590	No	No	No	003	No	No	No
J1599	No	4y & up	No	No	Yes	No	No
NOTE: 0	Claims are rev	iewed for med	ical necessity	based on the	e ICD diagr	nosis code	billed.
J1600	No	No	View ICD Codes.	No	No	No	No
J1610	No	No	No	003	No	No	No
J1620	No	No	No	003	No	No	No
J1626	No	No	No	003	No	No	No
J1630	No	No	No	003	No	No	No
J1631	No	No	No	003	No	No	No
J1640	No	No	View ICD Codes.	No	No	No	No
J1642	No	No	No	003	No	No	No
J1644	No	No	No	003	No	No	No
J1645	No	No	No	003	No	No	No
J1650	No	No	No	No	No	No	No
J1652	No	No	No	No	No	No	No
J1655	No	No	No	003	No	No	No
J1670	No	No	No	003	No	No	No
J1700	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1710	No	No	No	003	No	No	No
J1720	No	No	No	003	No	No	No
J1725	No	16y & up	View ICD Codes.	No	No	No	No

NOTE: Arkansas Medicaid will reimburse providers for 17-Hydroxyprogesterone Caproate, 1 mg per day under J1725 at a maximum of 250 units per day. J1725 will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. This drug may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days and continued until week 37 for delivery. J1725 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.), "Pregnancy with history of pre-term labor." J1725 requires NDC billing protocol. The administration fee for 17-Hydroxyprogesterone Caproate is included in the reimbursement fee allowed for this drug.

J1730	No	No	No	003	No	No	No
J1740	No	No	No	No	No	No	No
J1741	No	18y & up	No	No	No	No	No
J1742	No	No	No	003	No	No	No
J1743*	No	No	View ICD	No	No	No	Yes

NOTE: An evaluation by a physician with a specialty in clinical genetics documenting progress and response to the medication is required annually.

J1745* No No Yes No Yes No Yes

NOTE: J1745 is payable without an approval letter for beneficiaries under age 18 years when the ICD diagnosis code is one of the following: (View ICD Codes.). No other diagnosis is required. All other diagnoses for beneficiaries under age 18 years require a Prior Approval Letter.

For beneficiaries age 18 years and above, J1745 is payable when one of the following conditions exist:

Use an ICD diagnosis code of (View ICD Codes.) as the primary detail diagnosis AND a secondary diagnosis of (View ICD Codes.).

The following ICD diagnosis code (<u>View ICD Codes.</u>) requires a Prior Approval Letter from the Medical Director for Clinical Affairs. The request for approval must include documentation showing failed trial of **Enbrel** or **Humira**.

Claims must be submitted with any applicable attachments and will be manually reviewed prior to payment.

| J1750 | No | |
|-------|----|----|----|----|----|----|----|--|

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1756*	No	18y & up	View ICD Codes.	No	Yes	No	Yes
J1786	No	2y & up	View ICD Codes.	No	No	No	No
J1790	No	No	No	003	No	No	No
J1800	No	No	No	003	No	No	No
J1810	No	Nó	No	003	No	No	No
J1815	No	No	No	003	No	No	No
J1830	No	No	No	003	No	No	No
J1835	No	No	No	003	No	No	No
J1840	No	No	No	003	No	No	No
J1850	No	No	No	003	No	No	No
J1885	No	No	No	003	No	No	No
J1890	No	No	No	003	No	No	No
J1930	No	No	No	No	No	No	No
J1931*	No	No	View ICD Codes.	No	Yes	No	Yes
J1940	No	No .	No	003	No	No	No
J1950	No	No	No	003	No	No	No
J1953	No	17y & up	No	No	No	No	No
J1955	No	No	No	003	No	No	No
J1956	No	No	No	003	No	No	No
J1960	No	No	No	003	No	No	No
J1980	No	No	No	003	No	No	No
J1990	No	No	No	003	No	No	No
J2001	No	No	No	003	No	No	No
J2010	No	No	No	003	No	No	No
J2020	No	No	No	003	No	No	No
J2060	No	No	No	003	No	No	No
J2150	No	No	No	003	No	No	No
J2175	No	No	No	003	No	No	No
J2180	No	No	No	003	No	No	No
J2185	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2210	No	No	No	003	No	No	No
J2250	No	No	No	003	No	No	No
J2260	No	No	View ICD Codes.	No	No	No	No
J2270	No	No	No	003	No	No	No
J2271	No	No	No	003	No	No	No
J2275	No	No	No	003	No	No	No
J2278	No	No	No	003	No	No	No
J2280	No	No	No	003	No	No	No
J2300	No	No	No	003	No	No	No
J2310	No	No	No	003	No	No	No
J2320	No	No	No	003	No	No	No
J2323*	No	No	No	No	Yes	No	Yes
		d physical show Prior Approva		se of multiple	sclerosis m	ust be sub	mitted with the
J2353*	No	No	No	003	Yes	No	Yes
	No No	No No	No No	003	Yes Yes	No No	Yes Yes
J2353* J2354*	No		No	003	Yes	No	Yes
J2353* J2354* NOTE: A	No	No	No	003	Yes	No	Yes
J2353* J2354* NOTE: A J2355	No Prior Approv	No al Letter is req	No uired for a di	003 agnosis othe	Yes r than a Lis	No 003 diagn	Yes osis.
J2353* J2354* NOTE: A J2355 J2358	No Prior Approv	No al Letter is req No	No uired for a di No	003 agnosis othe	Yes r than a Lis	No 003 diagn	Yes osis.
J2353* J2354*	No Prior Approv No No	No al Letter is req No 18y &up	No uired for a di No No	agnosis othe	Yes r than a Lis No	No 1003 diagn	Yes osis. No No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370	No Prior Approv No No	No al Letter is req No 18y &up No	No uired for a di No No No	003 agnosis othe 003 003	Yes r than a Lis No No No	No No No	Yes osis. No No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400	No Prior Approv No No No	No al Letter is req No 18y &up No No	No uired for a di No No No	003 agnosis othe 003 003 003	Yes r than a Lis No No No No	No No No No	Yes osis. No No No No
J2353* J2354* NOTE: A J2355 J2358 J2360	No Prior Approv No No No No	No al Letter is req No 18y &up No No No	No uired for a di No No No No No No	003 agnosis othe 003 003 003 003 003	Yes T than a List No No No No No No	No No No No No	Yes osis. No No No No No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405 J2410	No Prior Approv No No No No No No No No No	No al Letter is req No 18y &up No No No No	No uired for a di No No No No No No No No No	003 agnosis othe 003 003 003 003 003 003	Yes r than a Lis No No No No No No No	No No No No No No	Yes osis. No No No No No No No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405	No Prior Approv No	No al Letter is req No 18y &up No No No No	No uired for a di No	003 agnosis othe 003 003 003 003 003 003 003	Yes r than a List No	No	Yes osis. No No No No No No No No No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425	No Prior Approv No	No al Letter is req No 18y &up No No No No No	No uired for a di No View ICD	003 agnosis othe 003 003 003 003 003 003 003 003 003	Yes r than a Lis No	No	Yes osis. No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426 J2430	No Prior Approv No	No al Letter is req No 18y &up No	No uired for a di No No No No No No No View ICD Codes.	003 agnosis othe 003 003 003 003 003 003 003 003 No	Yes r than a List No	No N	Yes osis. No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426	No Prior Approv No	No al Letter is req No 18y &up No	No uired for a di No No No No No No No View ICD Codes.	003 agnosis othe 003 003 003 003 003 003 003 003 003 00	Yes r than a Lis No	No N	Yes osis. No
J2353* J2354* NOTE: A J2355 J2358 J2360 J2370 J2400 J2405 J2410 J2425 J2426 J2430 J2440	No Prior Approv No	No al Letter is req No 18y &up No	No uired for a di No No No No No No No View ICD Codes. No	003 agnosis othe 003 003 003 003 003 003 003 No 003	Yes r than a Lis No	No N	Yes osis. No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2503	No	No	View ICD Codes.	No	No	No	No
J2504	No	No	View ICD Codes.	No	No	No	No
J2505	No	No	Yes	003	Yes	No	No
		e J2505 is pay Diagnosis cod					agnosis (<u>View</u>
J2507*	No	18 y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.

J2510	No	No	No	003	No	No	No
J2513	No	No	No	No	No	No	No
J2515	No	No	No	003	No	No	No
J2540	No	No	No	003	No	No	No
J2543	No	No	No	003	No	No	No
J2550	No	No	No	003	No	No	No
J2560	No	No	No	003	No	No	No
J2562	No	21y & up	No	No	No	Yes	No

NOTE: Procedure code J2562 is covered for ages 21 years and above and requires prior authorization by the 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.

J2590	No	No	No	003	No	No	No
J2597	No	No	No	No	No	No	No
J2650	No	No	No	003	No	No	No
J2670	No	No	No	003	No	No	No
J2675	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2680	No	No	No	003	No	No	No
J2690	No	No	No	003	No	No	No
J2700	No	No	No	003	No	No	No
J2710	No	No	No	003	No	No	No
J2720	No	No	No	003	No	No	No
J2725	No	No	No	003	No	No	No
J2730	No	No	No	003	No	No	No
J2760	No	No	No	003	No	No	No
J2765	No	No	No	003	No	No	No
J2770	No	No	No	003	No	No	No
J2778*	No	No	View ICD Codes.	No	Yes	No	Yes
J2780	No	No	No	003	No	No	No
J2783	No	No	No	003	No	No	No
J2788	No	No	No	No	No	No	No
J2790	No	No	No	No	No	No	No
J2791	No	No	No	No	No	No	No
J2792	No	No	No	No	No	No	No
J2796	No	19y & up	View ICD Codes.	No	No	No	No

NOTE: 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.

J2800	No	No	No	003	No	No	No
J2820	No	No	No	003	No	No	No
J2910	No	No	View ICD Codes.	No	No	No	No
J2916	No	No	No	No	No	No	No
J2920	No	No	No	003	No	No	No
J2930	No	No	No	003	No	No	No
J2941	No	No	No	003	No	No	No
J2950	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2993	No	No	No	No	No	No	No
NOTE:		nits per day in t ICD diagnosis				ose of dec	lotting
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE:		nits per day in t ICD diagnosis				ose of dec	lotting
J3000	No	No	No	003	No	No	No
J3010	No	No	No	003	No	No	No
J3030	No	No	No	003	No	No	No
J3070	No	No	No	003	No	No	No
J3095	No	18y & up	No	003	No	No	No
J3105	No	No	No	003	No	No	No
J3120	No	No	No	003	No	No	No
J3130	No	No	No	003	No	No	No
J3140	No	No	No	003	No	No	No
J3150	No	No	No	003	No	No	No
J3230	No	No	No	003	No	No	No
J3240	No	No	No	003	No	No	No
J3250	No	No	No	003	No	No	No
J3260	No	No	No	003	No	No	No
J3262*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3265	No	No	No	003	No	No	No
J3280	No	No	No	003	No	No	No
J3300	No	No	No	No	No	No	No
J3301	No	No	No	003	No	No	No
J3302	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3303	No	No	No	003	No	No	No
J3305	No	No	No	003	No	No	No
J3310	No	No	No	003	No	No	No
J3315	No	No	No	003	No	No	No
J3320	No	No	No	003	No	No	No
J3350	No	No	No	003	No	No	No
J3357*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

J3360	No	No	No	003	No	No	No
J3364	No	No	No	003	No	No	No
J3365	No	No	No	003	No	No	No
J3370	No	No	No	003	No	No	No
J3385*	No	4y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Covered for pediatric and adult beneficiaries who are symptomatic and require enzyme replacement therapy. 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.

	Well as cull	ont Symptom	J.				
J3396	No	No	View ICD Codes.	No	Yes	No	No
J3400	No	No	No	003	No	No	No
J3410	No	No	No	003	No	No	No
J3420	No	No	View ICD Codes.	No	No	No	No
J3430	No	No	No	003	No	No	No
J3465	No	No	No	No	No	No	No
NOTE:	Procedure of	code J3465 is	covered for non	-pregnant	beneficiaries	3.	
J3470	No	No	No	003	No	No	No
J3475	No	No	No	003	No	No	No
J3480	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	e Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J3485	No	No	No	003	No	No	No
J3487	No	No	Yes	003	Yes	No	No
NOTE: P	rocedure cod	e J3487 is vali	d with a prim	ary ICD diag	nosis of (Vi	ew ICD Co	odes.).
J3488	No	No	No	No	No	No	No
J3490*	U9	16y & up	View ICD Codes	No	No	No	No

NOTE: Arkansas Medicard will reimburse providers for "Compounded 17-Hydroxy-progesterone Caproate, 250 mg" per day under J3490-U9. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate 250 mg" may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD diagnosis code of (View ICD Codes.) "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."

J3520	No	No	No	003	No	No	No
J7178	No	No	View ICD Codes.	No	No	No	No
J7180	No	2y & up	View ICD Codes.	No	No	No	No
J7183	No	No	View ICD Codes.	No	No	No	No
J7185	No	21y – 65y	No	No	No	No	No
J7186	No	No	No	No	No	No	No
J7187	No	No	No	No	No	No	No
J7190	No	No	No	No	No	No	No
J7191	No	No	No	No	No	No	No
J7192	No	No	No	No	No	No	No
J7193	No	No	No	No	No	No	No
J7194	No	No	No	No	No	No	No
J7195	No	No	No	No	No	No	No
J7196	No	18y & up	View ICD Codes.	No	No	No	No
J7197	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedu Code	re Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J7198	No	No	No	No	No	No	No
J7199*	No	No	No	No	No	No	No
		tion, procedure rug, dosage an				er claim for	m with the
J7300	FP	No	No	No	No	No	No
NOTE:		de J7300 requir e Section 292.				on-hospital	based
J7302	FP	No	No	No	No	No	No
		de J7302 require Section 292.				on-hospital	based
J7303	FP	No	No	No	No	No	No
NOTE:		de J7303 requi e Section 292.				on-hospital	based
J7306	FP	No	No	No	No	No	No
		de J7306 require Section 292.				on-hospital	based
J7307	FP	No	No	No	No	No	No
NOTE:		de J7307 requi e Section 292.				n-hospital	based
J7308	No	No	No	003	No	No	No
J7310	No	No	No	003	No	No	No
J7312*	No	18y &up	View ICD Codes.	No	Yes	No	Yes

NOTE: Procedure code J7312 is covered for the allowable valid ICD diagnosis codes when the beneficiary has failed oral treatments and is untreatable by any other method.

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.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

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 **Hyaluronon** injection in the physician's office 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. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 261.200 for Utilization Review prior authorization information. The request must include the patient's name, Medicaid ID number, physician's 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. Refer to Section 261.200 for Prior Authorization.

	and our my out.	on procodure					
J7330	No	No	No	No	No	Yes	No
NOTE:			equires prior a 00, 261.100 ar		rom AFMC f	or all provide	rs. See
J7501	No	No	No	003	No	No	No
J7502	No	No	No	No	No	No	No
J7504	No	No	No	003	No	No	No
J7505	No	No	No	003	No	No	No
J7506	No	No	No	003	No	No	No
J7507	No	No	No	003	No	No	No
J7509	No	No	No	003	No	No	No
J7510	No	No	No	003	No	No	No
J7511	No	No	No	003	No	No	No
J7513	No	No	No	003	No	No	No
J7515	No	No	No	No	No	No	No
J7516	No	No	No	No	No	No	No
J7517	No	No	No	No	No	No	No
J7518	No	No	No	003	No	No	No
J7520	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedi Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
J7525*	No	No	No	No	Yes	No	No
NOTE:	For considerat name of the dr					er claim for	m with the
J7527	No	18y & up	View ICD Codes.	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE:	For considerat					er claim for	m with the
J8530	No	No	No	003	No	No	No
J8650*	No	No	No	No	No	No	No
J8705	No	No	No	003	No	No	No
J9000	No	No	No	003	No	No	No
J9002	No	18y & up	No	003	No	No	No
J9010	No	No	No	003	No	No	No
J9015	No	No	No	003	No	No	No
J9017	No	No	No	003	No	No	No
J9019*	No	2y-18y	No	No	Yes	No	Yes
J9020	No	No	No	003	No	No	No
J9025*	No	No	View ICD Codes.	No	No	No	Yes
J9031	No	No	No	003	No	No	No
J9033*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9035*	No	No	View ICD Codes.	No	Yes	No	Yes
J9040	No	No	No	003	No	No	No
J9041*	No	No	View ICD Codes.	No	Yes	No	Yes

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9042*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: Adcetris – After failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma diagnosis (View ICD Codes.) after failure of at least one prior multi-agent chemotherapy regimen. Documentation of above criteria must be submitted with current history and physical exam for Prior Approval letter from the Medicaid Director for Clinical Affairs. All previous chemotherapy regimens should be well documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of tisk of PML should be documented in medical records.

J9043* No 18y & up View ICD No Yes No Yes

NOTE: This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.

J9160	No	No	View ICD Codes.	No	Yes	No	Yes
J9155	No	21y & up	No	003	No	No	No
J9151	No	No	No	003	No	No	No
J9150	No	No	No	003	No	No	No
J9130	No	No	No	003	No	No	No
J9120	No	No	No	003	No	No	No
J9100	No	No	No	003	No	No	No
J9098	No	No	No	003	No	No	No
J9070	No	No	No	003	No	No	No
J9065	No	No	No	003	No	No	No
J9060	No	No	No	003	No	No	No
J9055*	No	No	View ICD Codes.	No	Yes	No	Yes
J9050	No	No	No	003	No	No	No
J9045	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	View ICD Codes.	003	Yes	No	Yes
J9179*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.

J9181	No	No	No	003	No	No	No
J9185	No	No	No	003	No	No	No
J9190	No	No	No	003	No	No	No
J9200	No	No	No	003	No	No	No
J9201	No	No	No	003	No	No	No
J9202	No	No	No	003	No	No	No
J9206	No	No	No	003	No	No	No
J9207*	No	21y & up	View ICD Codes.	No	Yes	No	Yes
J9208	No	No	No	003	No	No	No
J9209	No	No	No	003	No	No	No
J9211	No	No	No	003	No	No	No
J9212	No	No	No	003	No	No	No
J9213	No	No	No	003	No	No	No
J9214	No	No	No	003	No	No	No
J9215	No	No	No	003	No	No	No
J9216	No	No	No	003	No	No	No
J9217	No	No	No	003	No	No	No
J9218	No	No	No	003	No	No	No
J9219	No	No	View ICD Codes.	No	No	No	No

NOTE: For male beneficiaries of all ages. Benefit limit is one procedure every 12 months.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedi Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9225	No	No	View ICD Codes.	No	No	No	No
J9226*	No	0-12y	View ICD Codes.	No	Yes	No	Yes
NOTE:	should be cor luteinizing hor GnRH analog should include intracranial tu human choric and adrenal s must be docu	A: Prior to initial of immed by measurement (LH) and a sessme height and we imor), pelvic/testonic gonadotrop of teroids to exclusion requesting when requesting	surement of be follicle stimulent of bone apight measure ticular/adrenation levels (to redecongenitalical records	blood concentiating hormoge versus chements, diagral ultrasound ule out a choul adrenal hypand submitte	trations of tone (FSH) for ronological nostic imagination (to rule out prionic gona perplasia.	otal sex step bllowing stir age. Base ing of the b steroid sec dotropin se all tests and	eroids, mulation with a dine evaluations rain (to rule out creting tumors), creting tumor) I screenings
J9228*	No	18y & up	View ICD	No	Yes	No	Yes

NOTE: **Ipilmumab** is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.

Codes.

J9230	No	No	No	003	No	No	No
J9245	No	No	No	003	No	No	No
J9250	No	No	No	No	No	No	No
J9260	No	No	No	003	No	No	No
J9261*	No	No	View ICD Codes.	No	No	No	Yes

NOTE: The disease must have not responded to or has relapsed following treatment with at least 2 chemotherapy regimens.

J9263*	No	No	View ICD	No	Yes	No	Yes	
			Codes.					

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9264*	No	No	View ICD Codes.	No	Yes	No	Yes
J9265	No	No	No	003	No	No	No
J9266	No	No	No	003	No	No	No
J9268	No	No	No	003	No	No	No
J9270	No	No	No	003	No	No	No
J9280	No	No	No	003	No	No	No
J9293	No	No	Yes	No	Yes	No	No
NOTE: R	equires ICD	diagnosis code	e for cancer o	r ICD diagno	sis code of	(View ICD	Codes.).
J9300	No	No	No	003	No	No	No
				000	140	140	INO
J9303*	No	No	View ICD Codes.	No	Yes	No	Yes
J9303* J9305*	No						
J9305*		No	Codes. View ICD	No	Yes	No	Yes
	No	No No	View ICD Codes.	No No	Yes	No	Yes
J9305* J9307	No No	No No 18y & up	Codes. View ICD Codes. No	No No 003	Yes Yes No	No No	Yes Yes No
J9305* J9307 J9310	No No	No No 18y & up No	Codes. View ICD Codes. No No	No No 003	Yes Yes No	No No No	Yes Yes No

NOTE: The diagnosis must be for:

 Newly diagnosed glioblastoma multiform treated concomitantly with radiotherapy

OR

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

J9330	No	21y & up	View ICD Codes.	No	No	No	No
J9340	No	No	No	003	No	No	No
J9351	No	18y & up	No	003	No	No	No
J9355	No	No	No	003	No	No	No
J 9 357	No	No	No	003	No	No	No
J9360	No	No	No	003	No	No	No
J9370	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9390	No	No	No	003	No	No	No
J9395*	No	No	View ICD Codes.	No	Yes	No	Yes
J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No
NOTE: Se	ee Section 29	92.950 B for co	overage infor	mation.			
P9041	No	No	No	No	No	No	No
P9045	No	No	No	No	No	No	No
P9046	No	No	No	No	No	No	No
P9047	No	No	No	No	No	No	No
Q0139	No	No	View ICD Codes.	No	No	No	No
Q0162	UB	4y & up	No	No	No	No	No
NOTE: Q	O162-UB rep	resents "Onda	insetron 1 mg	, oral" billab	le electronica	ally or on pa	aper.
Q0166	UB	No	No	003	No	No	No
	se UB modificedicaid description	er for Q0166 – ription.	"Granistron F	ICI tab/Img,	oral" (Kytril)	. This is th	e Arkansas
Q2009	No	No	No	003	No	No	No
Q2017	No	No	No	003	No	No	No
Q2034	No	18y & up	No	No	No	No	No
Q2043*	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medication with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.

Q2049	No	18y & up	No	003	No	No	No	
Q3025	No	No	No	No	No	No	No	
Q3026	No	No	No	No	No	No	No	
Q4081	No	No	View ICD Codes.	No	No	No	No	

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approva Letter
Q4124	No	No	No	No	No	No	No .
Q9969	No	No	No	No	No	No	No
S0017	No	No	No	003	No	No	No
S0021	No	No	No	003	No	No	No
S0023	No	No	No	003	No	No	No
S0028	No	No	No	003	No	No	No
S0030	No	No	No	003	No	No	No
S0032	No	No	No	003	No	No	No
S0034	No	No	No	003	No	No	No
S0039	No	No	No	003	No	No	No
S0040	No	No	No	003	No	No	No
S0073	No	No	No	003	No	No	No
S0074	No	No	No	003	No	No	No
S0077	No	No	No	003	No	No	No
S0080	No	No	No	003	No	No	No
S0081	No	No	No	003	No	No	No
S0092	No	No	No	003	No	No	No
S0093	No	No	No	003	No	No	No
S0108	No	No	No	003	No	No	No
S0119	No	4y & up	No	No	No	Nø	No
S0145	No	No	View ICD Codes.	No	No	No	No
S0164	No	No	No	003	No	No	No
S0177	No	No	No	003	No	No	No
S0179	No	No	No	003	No	No	No
S0187	No	No	No	003	No	No	No
Z1847*	No	No	No	003	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.
List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedi Code	ure Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90284	No	No	No	No	Yes	No	No
NOTE:	90284 will be ap	proved for payr	ment based or	n diagnosis co	ode that pro	ves medical	necessity.
90375*	No	No	No	No	No	No	No
NOTE:	Each date of s be attached ald dosage, anato administration	ong with the cli mical site and	nical adminis	tration record	ds indicatin	g medical n	ecessity,
90376*	No	No	No	No	No	No	No
NOTE:	Each date of s be attached ald dosage, anator administration	ong with the cli mical site and	nical adminis	tration record	ds indicating	g medical n	ecessity,
90385	No	No	No	No	No	No	No
NOTE:	Procedure cod	e 90385 is limi	ted to one inj	ection per pr	egnancy.		
0386	No	No	No	No	No	No	No
0581*	No	18y & up	No	No	No	No	No
NOTE:	Indicate dose a	and attach mar	nufacturer's ir	nvoice.			
90632	No	19y & up	No	No	No	No	No
90662	No	65y & up	No	No	No	No	No
NOTE:	Procedure cod service on or a			eficiaries age	s 65 years	and older fo	or dates of
0675*	No	No	No	No	No	No	No
NOTE:	Procedure cod paper claims w for each date of indicated and r must be attach	vith procedure of service. If da must be identifi	code and dos ate spans are led for each o	sage entered used, appro date within the	in Field 24 priate units e span. Th	D of claim for of service of e manufact	orm CMS-1500 must be
90676*	No	No	No	No	No	No	No
NOTE:	Procedure cod paper claims w for each date of indicated and r must be attach	vith procedure of service. If da must be identifi	code and dos ate spans are ied for each o	sage entered used, appro date within th	in Field 24 priate units e span. Th	D of claim for service of service of the contract of the contr	orm CMS-1500 must be
90690	No	6y & up	No	No	No	No	No
90691	No	3y & up	No	No	No	No	No
90703	No	No	No	No	No	No	No

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol). See Sections 261.000 - 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003 diagnosis codes include (View ICD Codes.). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
90704	No	1y & up	No	No	No	No	No
90705	No	9m & up	No	No	No	No	No
90706	No	1y & up	No	No	No	No	No
90707	U1	21y - 44y	No	No	No	No	No
thro	ough 44, wh		sk of exposui	re to these di	seases. Co	dbearing age, overage is limite	
90707	No	19y - 20y	No	No	No	No	No
90708	No	9m & up	No	No	No	No	No
90717*	No	No	No	No	No	No	No
NOTE: Sub	mit invoice	with claim.					
90719	No	No	No	No	No	No	No
90725*	No	No	No	No	No	No	No
NOTE: Sub	mit manufa	acturer's invoic	e.				
90727*	No	No	No	No	No	No	No
NOTE: Sub	mit manufa	acturer's invoic	e.				
90732	No	2y & up	No	No	No	No	No
		1 years and old h risk. All ben				considered by ered high risk.	the
90733	No	No	No	No	No	No	No
90735	No	0 - 20y	No	No	No	No	No
90740	No	No	No	No	No	No	No
90746	No	19y & up	No	No	No	No	No
	No	No	No	No	No	No	No

procedure including documentation of medical necessity.

^{*}Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol).

Hyperalimentation Section II





Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Prosthetics

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal PROSTHET-5-15

REMOVE		INSERT	
Section	Date	Section	Date
		242.401	10-1-15
		242.402	10-1-15

Explanation of Updates

Section 242.401 is added to include National Drug Code (NDC) information.

Section 242.402 is added to include current drug vial policy.

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.

Dawn Stehle

Director

TOC required

242.401 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

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 Common Procedure Coding 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 website at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	The state of the s

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

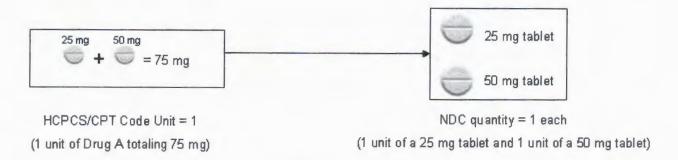
II. Claims Filing

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

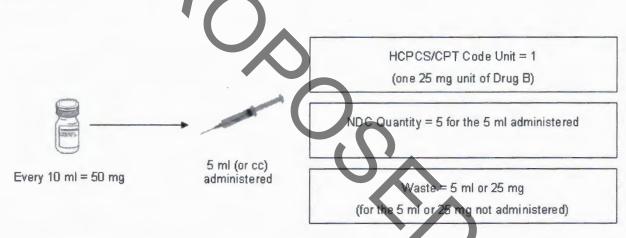
example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If 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. See Diagram 5.





A. Electronic Claims Filing - 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	sahe	00	YY	KANE	10	AA	PLACE		Ng.	CPTAKOPCS.	NUMBANGE N	The Thirt	ences Olosfasi	1	POWIER POWIER	1	\$ CHAMGES	CAN	Family Family Figs	9/4.	ABIDEANG PROVIDER D: #
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	N4	0111	122	2233	UN	1.00											,				123455789
	08	01	07	38	01	07	111	No.	286.66	Z1234		*	* ***	Chapt vi	1		0 00	0		NP1	
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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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 MI
3	1	4	4	4	4	4	5	5	5	5	0	6	26/89	T TO BIT USE TO	

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question

242.402 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Mark Up

TOC required

242.401 National Drug Codes (NDCs)

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

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 Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	ni y Annu
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

0-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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

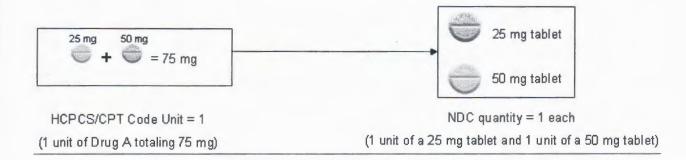
II. Claims Filing

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

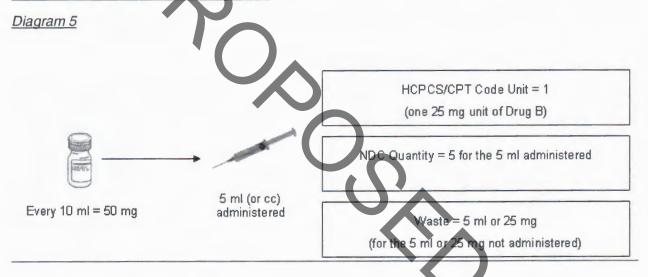
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Filing - 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	4694	DC Proper	YY AM	DC	84	PLACE O		CPTHOPCS		Consumal	ADÇAFIEJ	1	DICKGENOWS PIGRATER		3404,8434	0	D#15	Pandy Alas	394.	PROVIDER IO #
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Sequence 2	Sommerces	enmannike	1222333	ndinninno	1.00			Ann X Market Control									Long Company		***********	123456789
	08	01	97 08	01	07	111	1	Z1234		ji ji			1		0	00	0		3653	
Detail 2	3	4	lan	1	l mare	Lea	200	1 00040	*	*	7		14	1	55	ion l	4		34/19	123466789
	08 N4	4444	100 E DE	ML	500	111	.1	96213					endenimento e		- 30	1991				123466789
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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

2 3 4 5 6	7 0 0 1 2	71234 ABC drug/25 MG/Oral	-
	1 0 9 1 2	21234 · Abo diagr25 mororai	0
1 1 1 1 2	2 2 2 3 3	XYZ drug/50 MG/Oral	0
4 4 4 4 5	5 5 5 0 6	Z6789 PRO drug/5 ML/IV	5 ML
1	1 1 1 2 4 4 5	1 1 1 2 2 2 2 3 3 4 4 4 5 5 5 5 0 6	DDO Junis MIN

III. 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.

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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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question

242.402 Billing of Multi-Use and Single-Use Vials

10-1-15

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- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
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 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
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Remember to verify the milligrams given to the patient and then convert to the proper units for billing.



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

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437

501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Rural Health Clinic

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal RURLHLTH-2-15

REMOVE

INSERT

Section

Section

Date

Date

252.103

10-1-15

Explanation of Updates

Section 252.103 is added to include current drug vial policy.

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.

Dawn Stehle FIAN

Director

TOC required

252.103 Billing of Multi-Use and Single-Use Vials

10-1-15

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Mark Up

TOC required

252.103 Billing of Multi-Use and Single-Use Vials

10-1-15

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Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437 501-320-6428 · Fax: 501-404-4619 TDD/TTY: 501-682-6789



TO:

Arkansas Medicaid Health Care Providers - Nurse Practitioner

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal NURSEPRA-2-15

REMOVE		INSERT	
Section	Date	Section	Date
		252.438	10-1-15
_		252.439	10-1-15

Explanation of Updates

Section 252.438 is added to include National Drug Code (NDC) information.

Section 252.439 is added to include current drug vial policy.

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Thank you for your participation in the Arkansas Medicaid Program.

Das Stehle / TAH
Dawn Stehle

Director

TOC required

252.438 National Drug Codes (NDCs)

10-1-15

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00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	***************************************
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
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Diagram 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12845678901
1111-2222-33	01111222283
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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

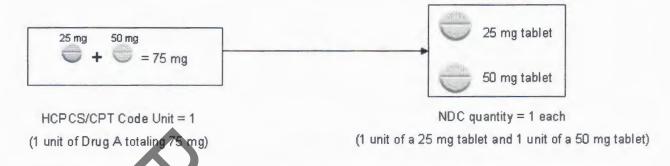
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

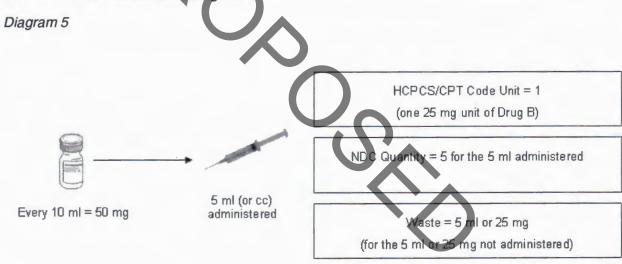
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

Each NDC when billed <u>under the same procedure code on the same date of service</u> 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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	3696	Prom EC:	Y.	teta V	E4 10		LACE OF	QMS.	(Expline CPTMOPC:	Chygudi F 3	Concaress in	ROYALINES BOOKER	99	DUNGA		1 CHARGES	CORP.	Trees.	ID. CUAL	PROVIDER D #
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-	1 144	qqqq	10000	OB M	L 3.	.0										All on X State 1				123466789
Sequence 1 4	+ 08	01	07 10	8 0	17 27	37	4		28789					1	-4	35 00	1	***************************************	MPS	

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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges \$6365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

TOC required

252.438 National Drug Codes (NDCs)

Mark-JD

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	10.00
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER	PRODUCT	PACKAGE
CODE	CODE	CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

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	011/104567

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

PCCS/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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

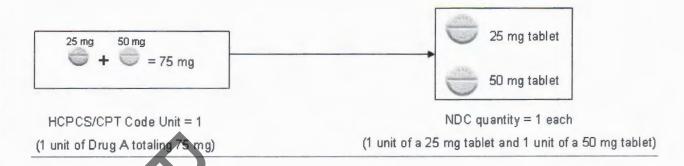
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

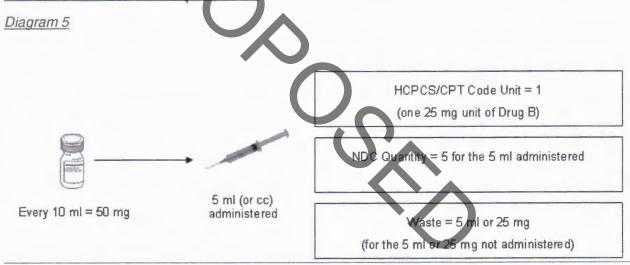
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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. See Diagram 5



A. Electronic Claims Filing - 837P (Professional) and 837I (Outpatient)

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

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	From E DO	V1 5153	00		LACEOF	6MG	CATACONCO	Nive and disk	C-PEMPAGE \$6	Parketi Contenti		PORTER PORTER	\$ CHARRY	6	CRE CRE Likelity	Marie Marie	CALVAL.	RENDERNO PROVIDER O. F
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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials

10-1-15

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges \$6365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug.

 The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.

 NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.



Division of Medical Services

Program Development & Quality Assurance





TO:

Arkansas Medicaid Health Care Providers - Transportation

DATE:

October 1, 2015

SUBJECT:

Provider Manual Update Transmittal TRANSP-1-15

REMOVE		INSERT	
Section	Date	Section	Date
252.100	12-2-11	252.100	10-1-15
252.110	12-2-11	252.110	10-1-15

Explanation of Updates

Section 252.100 is updated to include current drug vial policy.

Section 252.110 is updated to include National Drug Code (NDC) information.

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.

Days Stulle / Jaks
Dawn Stehle
Director

-..----

TOC not required

252.100

Ambulance Procedure Codes

10-1-15

The covered ambulance procedure codes are listed below.

Drug procedure codes require National Drug Codes (NDC) billing protocol. See Section 252.110 below.

A0382	A0398	A0422	A0425	A0426	A0427	A0429	J0150*
J0171*	J0280*	J0461*	J1094*	J1100*	J1160*	J1200*	J1265
J1940*	J2060*	J2175*	J2270*	J2310*	J2550*	J2560*	J3360*
J3410*	J3475*	J3480*	J3490*	93041*			

^{*}Procedure code can be billed only in conjunction with procedure code A0427

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - Documentation: The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Procedure Code	Required Modifier	Description	

Procedure Code	Required Modifier	Description
A0422	U1	Emergency, oxygen, helicopter air ambulance
A0425		Ground mileage per statute mile
A0428		Ambulance service, basic life support non-emergency transport
A0431		Ambulance service, emergency, basic pick-up, helicopter, one unit per day
A0434		Air Ventilator/Respiratory Therapist, one unit equals one hour (Round to the nearest hour)
A0435	U1, UB U2, UB U3, UB U4, UB U5, UB U6, UB	Piston propelled fixed wing air ambulance per mile Turboprop fixed wing air ambulance per mile Jet (fixed wing) one unit equals one mile Piston propelled fixed wing air ambulance per hour (Round to the nearest hour) Turboprop fixed wing air ambulance per hour (Round to the nearest hour) Jet (fixed wing) one unit equals one hour (Round to the nearest hour)
A0436		Emergency, per mile, loaded, helicopter air ambulance

252.110 National Drug Codes (NDC) Billing Protocol

10-1-15

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding 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 website at

https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the website. See Diagram 1 for an example of this screen. 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.

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	
00005	LEDERLE LABORATORIES	1/1/1991	
00006	MERCK & CO., INC.	1/1/1991	Name of the last o
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 Medicald 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 2 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 2

00123	0456	78
LABELER CODE	PRODUCT CODE	PACKAGE CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid.

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC
	rioquios II aigit II2

	(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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

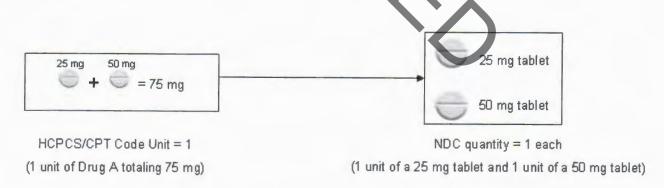
Exception: There is no requirement for an NDC when billing for vaccines.

II. Claims Filing

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

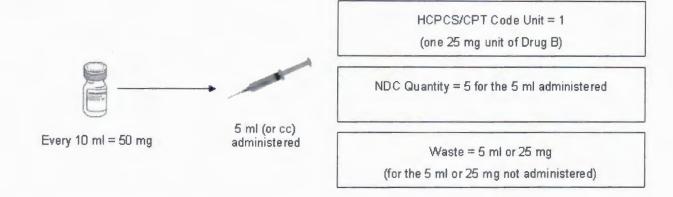
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.





Example 2: If 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. See Diagram 5.

Diagram 5



A. Electronic Claims Filing – 837P (Professional)

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.

B. Paper Claims Filing - CMS-1500

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

See Diagram 6 for CMS-1500.

CMS-1500

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 detail field 24F and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	24: 1	A. B. Butt EO	ATEXIN C	Nº JULIE MIN	2.0 00	4.4	PLACE OF		SEMPHANENCE SEMPHANENCE OFFERENCE		SWONTHAN		PPLES A	POPTER	F. SHAPOET		CIR UNITS	Samuel State	IQ. OLNE.	PROVIDER ID 4
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Sequence 2	08	01	07	80	01	07	111		Z1234	-	1	-		1	25	00	4		3654	
Doddorico z	n4	011	11222	233	UN	1.00		***************************************												123458789
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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 7 for an example of the completed form. Section V of the provider manual includes this form.

Complete instructions for accurate completion of form DMS-664 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

Diagram 7

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

III. 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.

IV. 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.

V. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 252.100 for additional information regarding drug code billing.

Mark Up

TOC not required

252.100

Ambulance Procedure Codes

12-2-1110-1-15

The covered ambulance procedure codes are listed below.

Drug procedure codes require National Drug Codes (NDC) billing protocol. See Section 252.110 below.

A0382	A0398	A0422	A0425	A0426	A0427	A0429	J0150*
J0171*	J0280*	J0461*	J1094*	J1100*	J1160*	J1200*	J1265
J1940*	J2060*	J2175*	J2270*	J2310*	J2550*	J2560*	J3360*
J3410*	J3475*	J3480*	J3490*	93041*			

^{*}Procedure code can be billed only in conjunction with procedure code A0427

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
 - Single-Use Vials: If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
 - 2. Multi-Use Vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient. NOTE: The leftover amount must be discarded and may not be used or billed for another patient.
 - 3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
 - 4. Paper Billing: 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.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Procedure	Required	
Code	Modifier	Description

Procedure Code	Required Modifier	Description
A0422	U1	Emergency, oxygen, helicopter air ambulance
A0425		Ground mileage per statute mile
A0428		Ambulance service, basic life support non-emergency transport
A0431		Ambulance service, emergency, basic pick-up, helicopter, one unit per day
A0434		Air Ventilator/Respiratory Therapist, one unit equals one hour (Round to the nearest hour)
A0435	U1, UB U2, UB U3, UB U4, UB U5, UB	Piston propelled fixed wing air ambulance per mile Turboprop fixed wing air ambulance per mile Jet (fixed wing) one unit equals one mile Piston propelled fixed wing air ambulance per hour (Round to the nearest hour) Turboprop fixed wing air ambulance per hour (Round to the nearest hour) Jet (fixed wing) one unit equals one hour (Round to the nearest hour)
A0436		Emergency, per mile, loaded, helicopter air ambulance

252,110

National Drug Codes (NDC) Billing Protocol

2-2-1110-

1-15

I. National Drug Codes

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deticit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Financing Administration Common Procedure Codinge 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_at https://arkansas.magellanrx.com/provider/documents.

A complete listing of "Covered Labelers" is located on the Arkansas Medicaid Web page at https://www.medicaid.state.ar.us/, click on Provider Services, select Prescription Drug information, and then select Covered Labelers. website. See Diagram 1 for an example of this screen. 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.

Diagram 1

LABELER	LABELER NAME	EFFECTIVE DATE	TERMINATION DATE
00002	ELI LILLY AND COMPANY	. 1/1/1991	
00003	E.R. SQUIBB & SONS, INC	1/1/1991	
00004	HOFFMANN-LA ROCHE	1/1/1991	1
00005	LEDERLE LABORATORIES	1/1/1991	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
00006	MERCK & CO., INC.	1/1/1991	
00007	GLAXOSMITHKLINE	1/1/1991	
00008	WYETH LABORATORIES	1/1/1991	
00009	PFIZER, INC.	1/1/1991	
00011	BECTON DICKINSON MICROBIOLOGY SYSTEMS	10/1/1991	7/1/1998
00013	PFIZER, INC.	1/1/1991	

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 2 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 2

00123	0456	78
LABELER CODE	PRODUCT CODE	PACKAGE CODE
(5 digits)	(4 digits)	(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 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid.

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 HCPCS/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. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. 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.

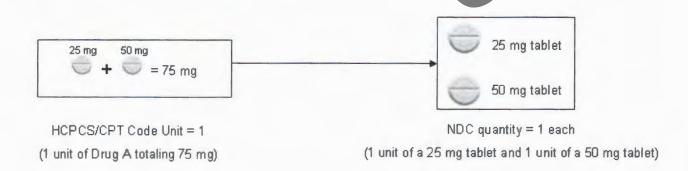
Exception: There is no requirement for an NDC when billing for vaccines.

II. Claims Filing

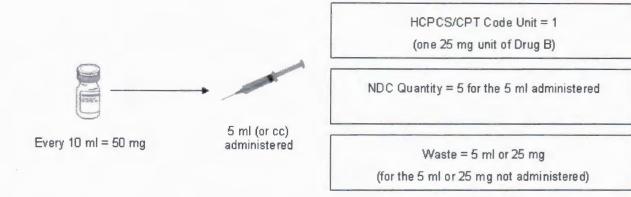
The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

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 4



Example 2: If 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. See Diagram 5.



A. Electronic Claims Fling - 837P (Professional)

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 837P professional claims, from the Service 2 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.
- 2. 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 https://www.medicaid.state.ar.us/. Click on Provider, select HIPAA, select Documents for vendors and then select Companion guides.

B. Paper Claims Filing – CMS-1500

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

See Diagram 6 for CMS-1500.

CMS-1500

For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML - Milliliter; UN – Unit), and the number of units of the actual NDC administered in the shaded area above detail field 24A, spaced and arranged exactly as in Diagram 6.

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 field 24F

and total HCPCS/CPT code units in detail field 24G. Each subsequent sequence number should show zeros in detail fields 24F and 24G. See Detail 1, sequence 2 in Diagram 6.

The quantity of the NDC will be the total number of units billed for each specific NDC. See Diagram 6, 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 6

Sequence 1	DA A	Frue DO:	AA YAARUM S	5699	Ye DO	YY	PLACE OF	EMO		Euglish U MICPOS	USS, SER Victorial C	REMARKS			SHAGNOSHI AGARTEA	1 CHARGE	8	CHATS-	SPECIFICATION OF THE PARTY OF T	FISH COLUMN	RENDERING. +
Sequence 1	N4	123	45678	12	UN	100	off photococciniti	obcommon	alexadence.		uncodigospococo.		100-40000000000000000000000000000000000		***************************************	-					123455789
Sequence 2	08	01	07	08	01	07	111		Z1	234		3			14	25	00	4		1681	
9	N4	011	11222	233	UN	100			v	***************************************	~		,				,				123466789
Žio.	08	01	07	08	01	07	111		Z1	234	*	ab contract	-		1	Ö	00	0		16871	** ** ** ** ** * * * * * * * * * * * * *
Detail 2					:			_				4	3	4					,		123466789
	08	01	07	08			111		96	2213	1	8	1		1	55	00	1		3401	
A 4	144	444	99555	5006	dc.	5.00															123456789
Sequence 1 4	08	01	07	58	01	07	111	1	Z	3789	:17		1		1	35	00	1		36839	
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eren 2						3					200	8	1	1	and a second					HPI .	

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 7 for an example of the completed form. Copies of the DMS-664 will not be provided. Section V of the provider manual includes this form.

Complete instructions for accurate completion of form DMS-664 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

Diagram 7

Detail #	Sequence #						NDC						Proc Code /Modifier				
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		

III. 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.

IV. 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.

V. 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," then select "Prescription Drug Information" and then select "DESI NDCs (non-payable) associated with HCPCS/CPT Codes." See Diagram 8 for an example of the DESI list.

Diagram 8

	DESI NDCs (non	ARKANSAS MEDICAID payable) associated with He	CPCS/CPT Codes	
Fo	or further information — p	lease contact EDS Pharmacy		
NDC	DESI Drug Begin Date	Brug Label Name	Drug Manufacturer Name	ed 10/15/200
	near mind pedin nate	DEPO-TESTADIOL VIAL	PHARMACIA/UPJHN	J1060

VI. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength and amount) was administered and on what date, to the beneficiary in question.

See Section 252.100 for additional information regarding drug code billing.