ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: Arkansas Medicaid Health Care Providers – ARKids First-B

DATE: November 1, 2015

SUBJECT: Provider Manual Update Transmittal ARKIDS-3-15

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	262.431	11-1-15

Explanation of Updates

Section 262.431 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 is required

262.431 Billing of Multi-Use and Single-Use Vials 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

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

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal ASC-2-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
242.400	7-1-14	242.400	11-1-15
242.410	7-1-14	242.410	11-1-15

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) 11-1-15

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. 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

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 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 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.

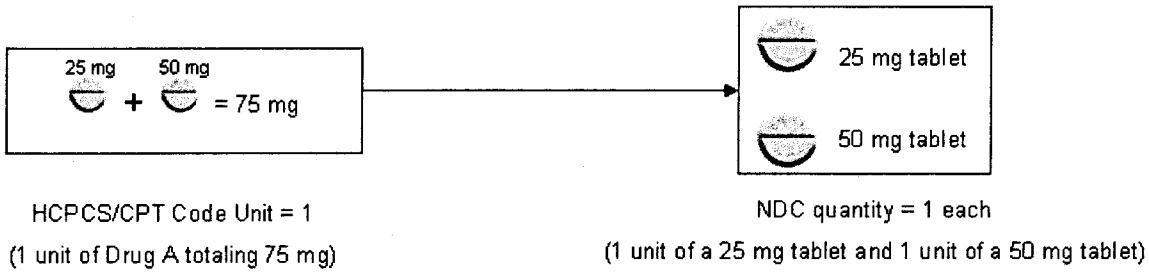
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

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

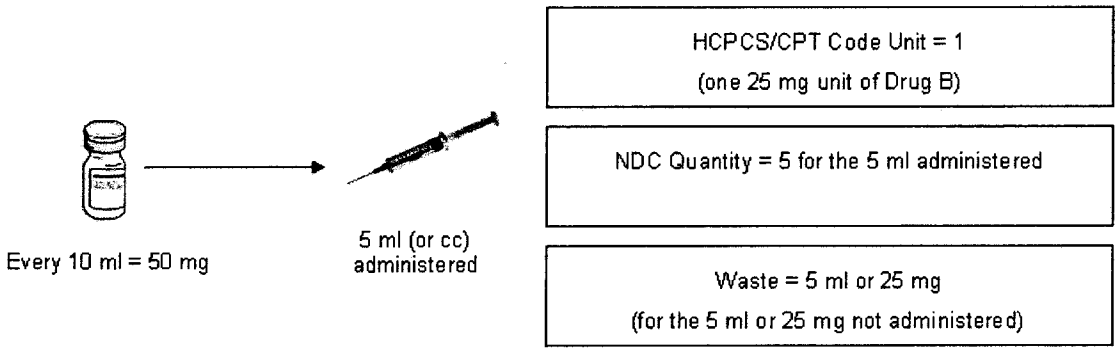
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

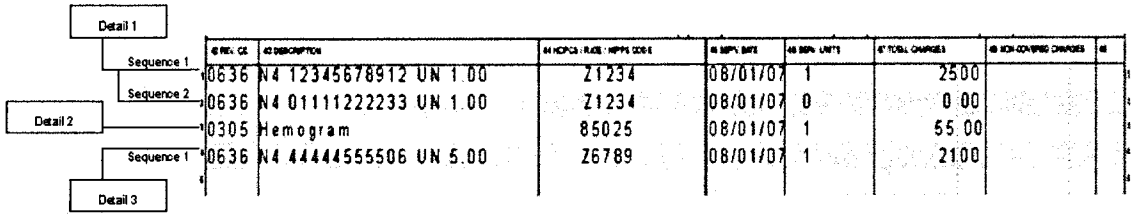
E. Paper Claims Filing CMS-1450 (UB-04)

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



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. **View or print form DMS-664 and instructions for completion**.

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

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. 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 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Certified Nurse-Midwife**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal CNM-1-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
_____	_____	272.531	11-1-15
_____	_____	272.532	11-1-15

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.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

TOC required

272.531 National Drug Codes (NDCs) **11-1-15**

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

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 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 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.

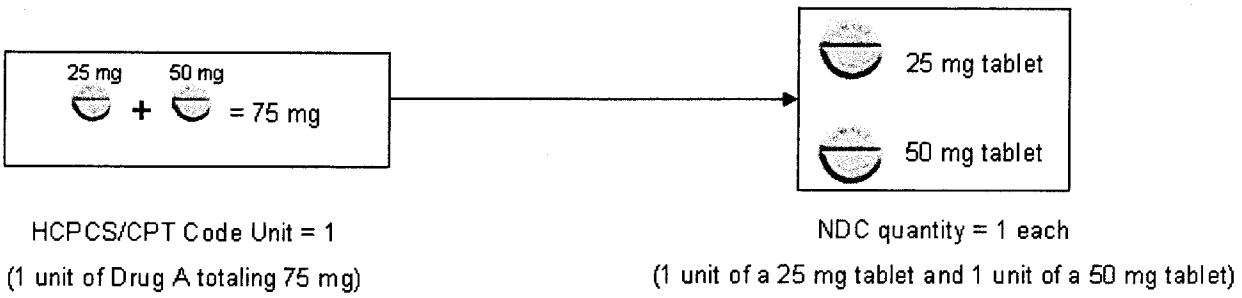
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

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

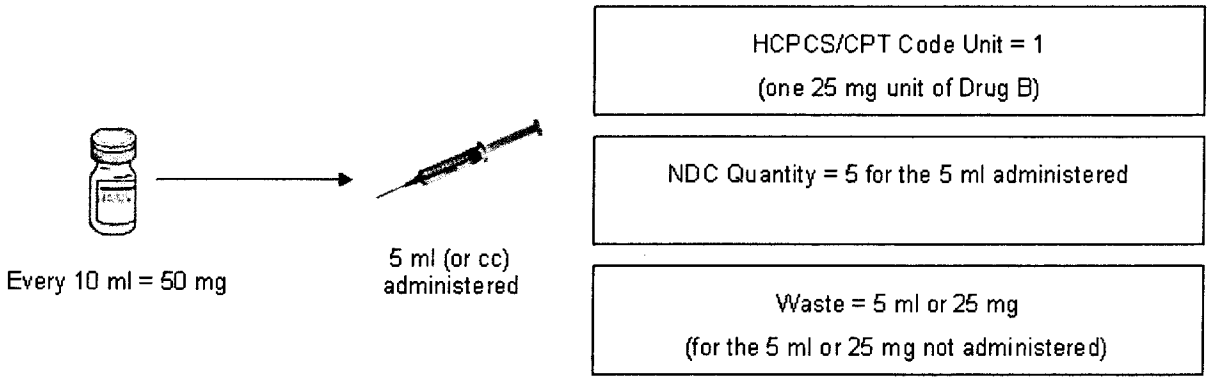
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

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.

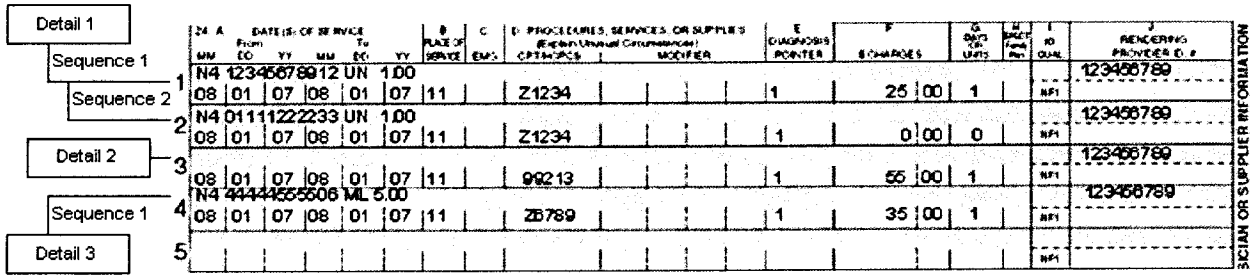
For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

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



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.

See Section 272.532 for additional information regarding drug code billing.

272.532 Injections, Therapeutic and/or Diagnostic Agents 11-1-15

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.

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal EPSDT-2-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
_____	_____	242.141	11-1-15

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.

Dawn Stehle
Director

TOC required

242.141 Billing of Multi-Use and Single-Use Vials 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Federally Qualified Health Center**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal FQHC-2-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	262.441	11-1-15
—	—	262.442	11-1-15

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
Director

TOC required

262.441 National Drug Codes (NDCs) 11-1-15

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

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 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 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.

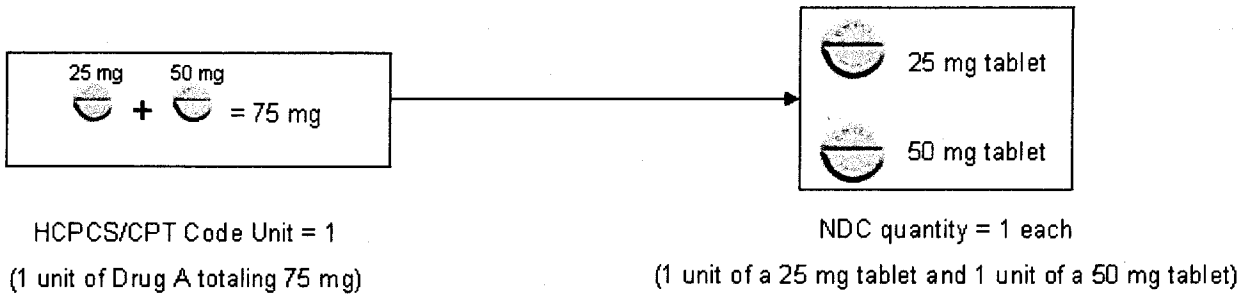
II. Claims Filing

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

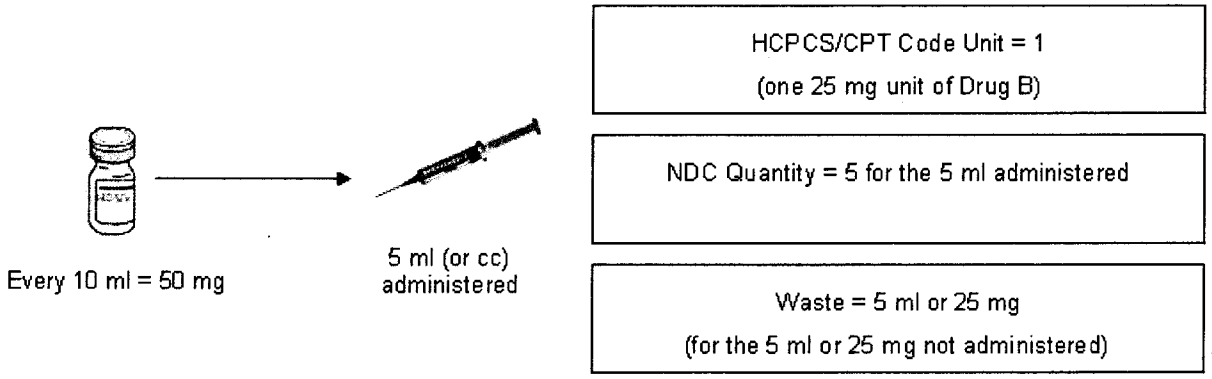
example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

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.

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.

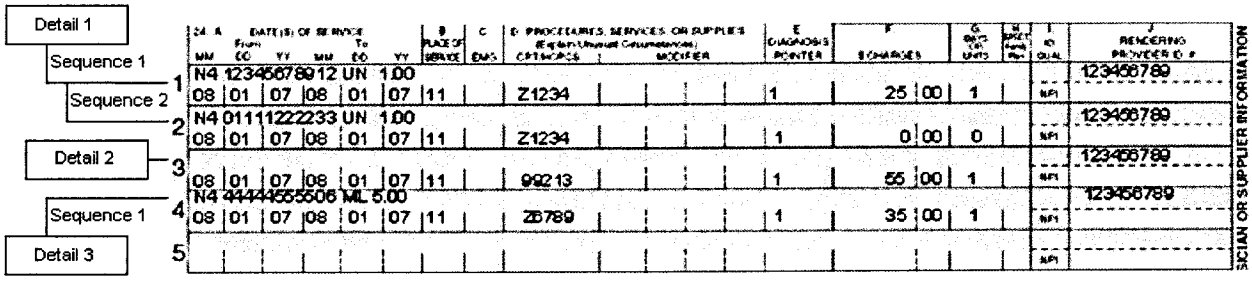
See Diagram 6 for CMS-1500.

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



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	12345678912	Z1234	ABC drug/25 MG/Oral	0
1	2	01111222233	Z1234	XYZ drug/50 MG/Oral	0
3	1	44444555506	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 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: Arkansas Medicaid Health Care Providers – Home Health

DATE: November 1, 2015

SUBJECT: Provider Manual Update Transmittal HOMEHLTH-3-15

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	242.143	11-1-15
—	—	242.144	11-1-15

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.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director

TOC required

242.143 National Drug Codes (NDCs) 11-1-15

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.

Diagram 1

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

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

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

Diagram 2

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

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

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

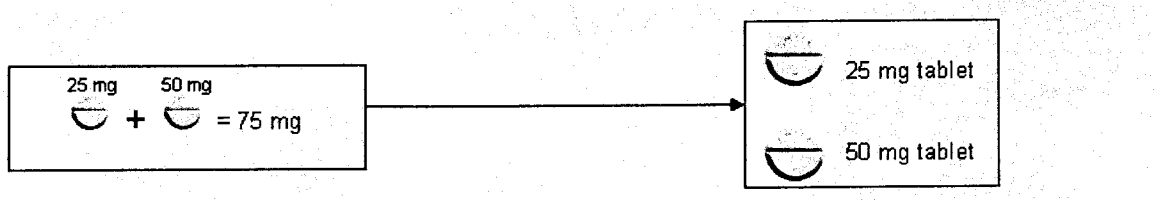
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals and allergen immunotherapy.

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.

Diagram 3

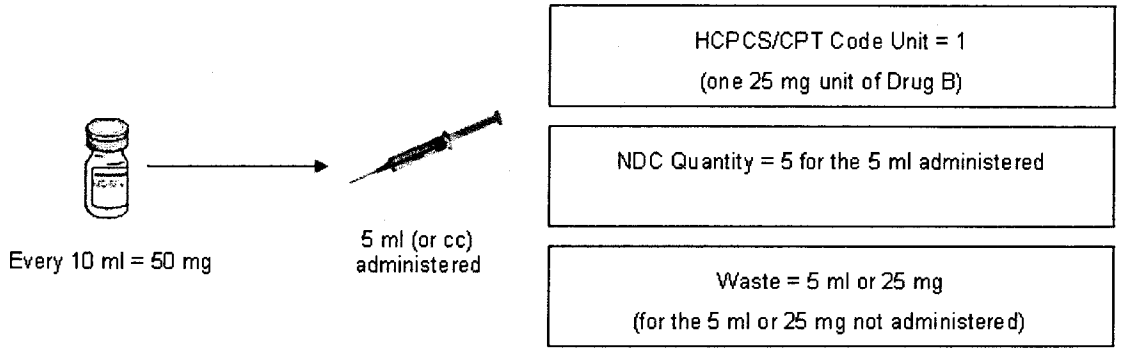


HCPCS/CPT Code Unit = 1
(1 unit of Drug A totaling 75 mg)

NDC quantity = 1 each
(1 unit of a 25 mg tablet and 1 unit of a 50 mg tablet)

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.

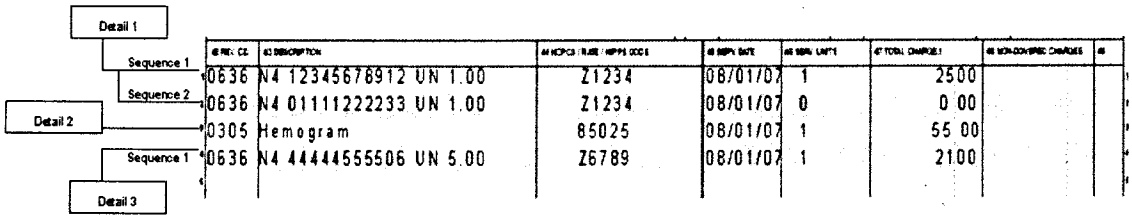
Arkansas Medicaid will require providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

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.

Diagram 5



0636	N4 12345678912 UN 1.00	Z1234	08/01/07	1	25.00	
0636	N4 01111222233 UN 1.00	Z1234	08/01/07	0	0.00	
0305	Hemogram	85025	08/01/07	1	55.00	
0636	N4 44444555506 UN 5.00	Z6789	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. 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 11-1-15

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.

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 units administered to the beneficiary.

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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD)**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal HOSPITAL-3-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
272.102	5-17-10	272.102	11-1-15
272.510	1-15-15	272.510	11-1-15

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) 11-1-15

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

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

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

Diagram 2

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

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

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

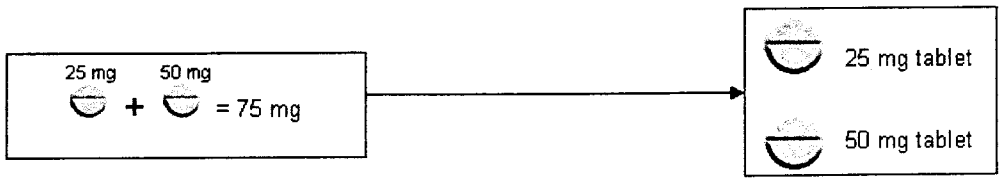
Exception: There is no requirement for an NDC when billing for vaccines.

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



HCPCS/CPT Code Unit = 1

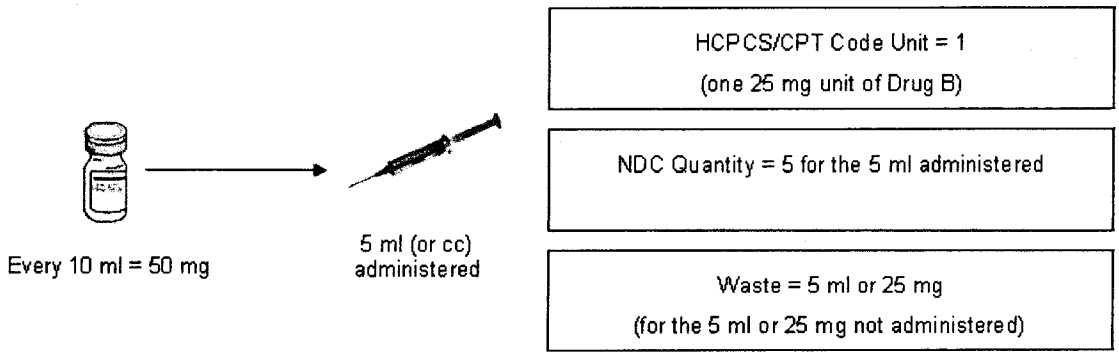
(1 unit of Drug A totaling 75 mg)

NDC quantity = 1 each

(1 unit of a 25 mg tablet and 1 unit of a 50 mg tablet)

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.

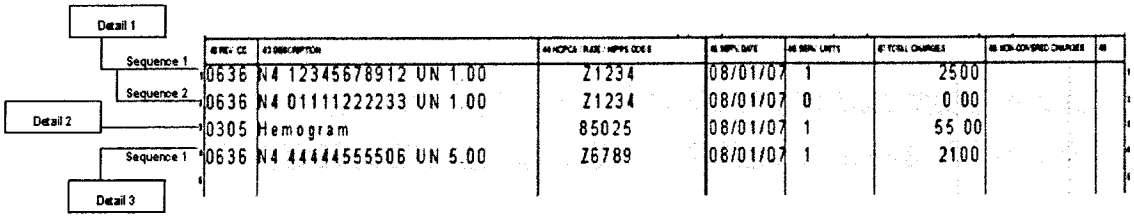
Arkansas Medicaid will require providers using Provider Electronic Solutions (PES) to use the required NDC format when billing HCPCS/CPT codes for administered drugs.

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.

Diagram 5



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

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

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. 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 11-1-15

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.

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.
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 units administered to the beneficiary.
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.
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-9-CM primary diagnosis restrictions.
5. The **fifth** 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 **sixth** column indicates whether a procedure is subject to medical review before payment.

7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 241.000 for prior authorization.)

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. (See Section 272.103 for Prior Approval.) **View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services.**

*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
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
NOTE: A9542 – A9545 require the Federal Drug Administration (FDA) approved diagnosis clearly stated. Treatment failures that the patient previously experiences and the patient's history and physical examination must be submitted.							
A9547*	No	No	No	No	No	No	Yes
NOTE: Prior Approval is required before services associated with the use of the procedure code must be provided. To obtain Prior Approval, a copy of the patient's history and physical exam must be submitted along with a report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic.							
A9555*	No	No	No	No	No	No	No
NOTE: To obtain Prior Approval, a copy of the patient's history and physical exam must be submitted along with a report on what other profusion scans have been tried and are non-diagnostic and attach a copy of the manufacturer's invoice to the claim.							
A9557	No	No	430-434.91	No	No	No	No
A9559*	No	No	281.0	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
A9563	No	No	238.4	No	No	No	No
A9575	No	2y& up	No	No	No	No	No
A9580*	No	No	198.5	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
A9581	No	21y & up	No	No	No	No	No
A9582*	No	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
A9585*	No	2y & 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.
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
A9586*	No	18y & up	331.0-332.1	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
A9604*	No	21y & up	No	003	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
C1841*	No	No	362.74	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim.							
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 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
C9441	No	18y & up	280.0-280.9 **AND** 285.1 **OR** 585.1-585.9	No	No	No	No
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 anti-rheumatic 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 units allowed 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 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
J0178*	No	18y & 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.							
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 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	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 1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1-proteinase 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).
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
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 reviewed for medical necessity based on ICD-9-CM diagnosis code.							
J0586	No	No	No	No	Yes	No	No
NOTE: This procedure code is reviewed for medical necessity based on an ICD-9-CM diagnosis code billed.							
J0588	No	18y & up	No	No	Yes	No	No
NOTE: An ICD-9-CM diagnosis code which supports medical 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).
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
J0595	No	No	No	003	No	No	No
J0597*	No	13y & up	277.6	No	Yes	No	No
NOTE: This code will be reviewed for medical necessity based on the clinical documentation submitted.							
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**: 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 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.
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 **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

*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

*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
J0881	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-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 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: See procedure code J0881 in this section for specific criteria. When the beneficiary is not on dialysis, use ICD-9-CM 285.21.

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 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
J0894*	No	No	205.00-205.91 237.71-238.76 238.79	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 (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 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
J1050	^	10y & up	^	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.						
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 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
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).
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
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.							
J1557	No	2y & up	No	No	Yes	No	No
NOTE: An ICD-9-CM diagnosis code that supports medical necessity is required.							
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 reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.							
J1566	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.							
J1568	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD-9-CM diagnosis code billed.							
J1569	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the 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 reviewed for medical necessity based on the 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 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
J1602*	No	18y & up	556.0-556.9 696.0 714.0-714.9 721.9	No	Yes	No	Yes

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	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 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	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 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

*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
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
NOTE: The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the Prior Approval Letter.							
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 Approval Letter is required for a diagnosis other than a List 003 diagnosis.							
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).
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
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). Diagnosis codes must be shown on the claim form.							
J2507*	No	18y & up	274.00-274.03	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
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.
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 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
J2993	No	No	No	No	No	No	No
NOTE: For the purpose of declotting catheters, bill diagnosis 996.74 on the claim.							
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE: For the purpose of declotting catheters, bill diagnosis 996.74 on the 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
NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A complete history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.							
J3070	No	No	No	003	No	No	No
J3095	No	18y & up	No	003	No	No	No
J3101	No	21y & up	410.00 or 410.92	003	Yes	No	No
NOTE: Ages 0-20 years have no restrictions.							
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
J3243	No	No	No	No	No	No	No
J3246	No	No	No	No	No	No	No
J3250	No	No	No	003	No	No	No
J3260	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
J3262*	No	18y & 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 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
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: Procedure code J3465 is covered for non-pregnant beneficiaries.							
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
J3490*	No	No	No	003	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).
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
J3490	U9	16y & 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	No	No	No	No	No	No
J7301	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
J7302	No	No	617.0-617.9 627.2 627.8 **OR** 627.9	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 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
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: Procedure code J7330 requires prior authorization from AFMC for all providers. See Section 241.000 for more information on obtaining prior authorization from AFMC.

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 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
J7520	No	No	No	No	No	No	No
J7525*	No	No	No	No	Yes	No	No
NOTE: For consideration, procedure code J7525 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.							
J7527	No	18y & up	V42.0	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 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.							
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	205.00-205.92 238.71-238.76 or 238.79	No	No	No	Yes
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	200.30-200.48 202.00-202.08 203.00 203.10 203.80 204.10-204.12 or 238.6	No	Yes	No	Yes

*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	153.0-154.8 162.0-162.9 174.0-175.9 or 189.0-189.9	No	Yes	No	Yes
J9040	No	No	No	003	No	No	No
J9041*	No	No	203.00-203.82 200.40-200.48	No	Yes	No	Yes
J9042*	No	18y & up	200.60-200.68, 201.00-201.98	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, 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 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
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	140.0-149.9 153.0-154.8 160.0-161.9 171.0 172.0-172.4 173.00-173.49 **OR** 195.0	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	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 beneficiaries 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.
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	201.10-202.18 202.20-202.28 **OR** 202.80-202.88	No	Yes	No	Yes
J9165	No	No	No	003	No	No	No
J9171	No	No	No	003	No	No	No
J9178*	No	No	150.0-150.8 151.0-151.9 162.0-162.9 171.0-171.9 174.0-175.9 183.0 200.00-200.88 Or 202.00-202.98	003	Yes	No	Yes
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 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
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 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
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 204.00-208.92	No	Yes	No	Yes

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

*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
J9264*	No	No	140.0-149.9 154.2-154.3 157.0-157.3 157.8 157.9 158.8 160.0-162.9 174.0-175.9 183.0-183.9 195.0	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: Requires ICD-9-CM diagnosis code for cancer or ICD-9-CM diagnosis code 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 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
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

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).
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
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	174.0-175.9	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 252.111 in this manual for coverage information.							
P9012*	No	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice to the claim. See Section 272.443 for additional information.							
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 represents "Ondansetron 1 mg, oral" billable electronically or on paper.							
Q0166	UB	No	No	003	No	No	No
NOTE: Use UB modifier for Q0166 –"Granistron HCl tab 1 mg, oral" (**Kytril**). This is the Arkansas Medicaid description.							
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.
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 manufacturer's invoice to the claim.							
Q4145*	No	No	No	No	No	No	No
NOTE: Attach the manufacturer's invoice 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 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
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: Procedure code Z1847 is for Torecan 10 mg oral tablets. Limit of (4) 10 mg tabs per day.

90375*	No	No	No	No	No	No	No

NOTE: Each date of service must be billed on a separate detail. Attach the manufacturer's invoice along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration to the claim. Reimbursement rate includes administration fee.

*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
90376*	No	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. Attach the manufacturer's invoice along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration to the claim. Reimbursement rate includes administration fee.							
90385	No	No	No	No	No	No	No
NOTE: Procedure code 90385 is limited to one injection per pregnancy.							
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE: Indicate dose and attach the manufacturer'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 code 90662 is covered for beneficiaries ages 65 years and older for dates of service on or after October 11, 2010.							
90673	No	19y-49y	No	No	No	No	No
90675*	No	No	No	No	No	No	No
NOTE: Procedure code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in claim form CMS-1450 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. Attach the manufacturer's invoice to the claim. Reimbursement rate includes administration fee.							
90676*	No	No	No	No	No	No	No
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in claim form CMS-1450 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. Attach the manufacturer's invoice to the claim. Reimbursement rate includes administration fee.							
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
90705	No	1y & up	No	No	No	No	No
90706	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 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
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	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: Attach the manufacturer's invoice to the claim.							
90732	No	2y & up	No	No	No	No	No
NOTE: Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.							
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: Zoster vaccine is benefit limited to once in a lifetime.							
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
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Hyperalimentation**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal HYPER-2-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	242.401	11-1-15
—	—	242.402	11-1-15

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) 11-1-15

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

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 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 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.

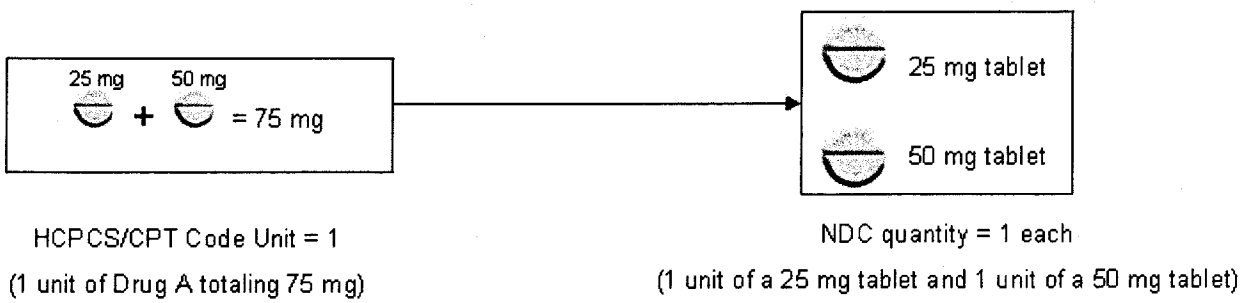
II. Claims Filing

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

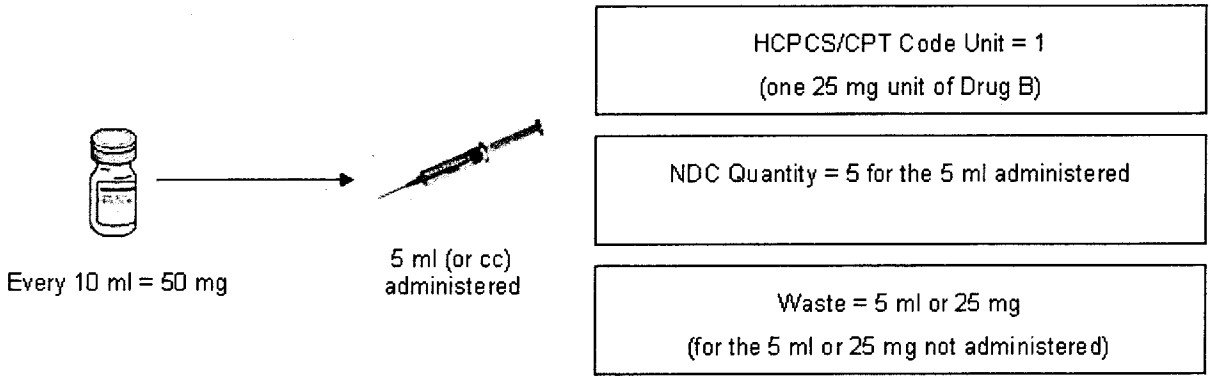
at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

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.

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.

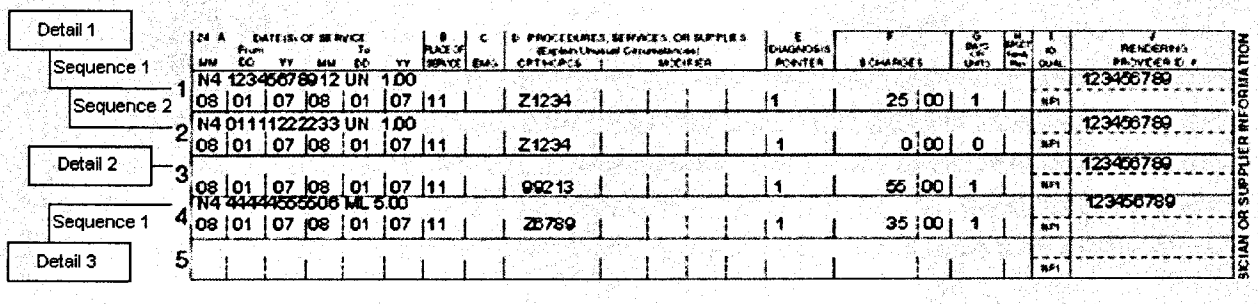
See Diagram 6 for CMS-1500.

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



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	12345678912	Z1234	ABC drug/25 MG/Oral	0
1	2	01111222233	Z1234	XYZ drug/50 MG/Oral	0
3	1	44444555506	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 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Nurse Practitioner**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal NURSEPRA-2-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	252.438	11-1-15
—	—	252.439	11-1-15

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.

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

252.438 National Drug Codes (NDCs) 11-1-15

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	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	

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 (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 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.

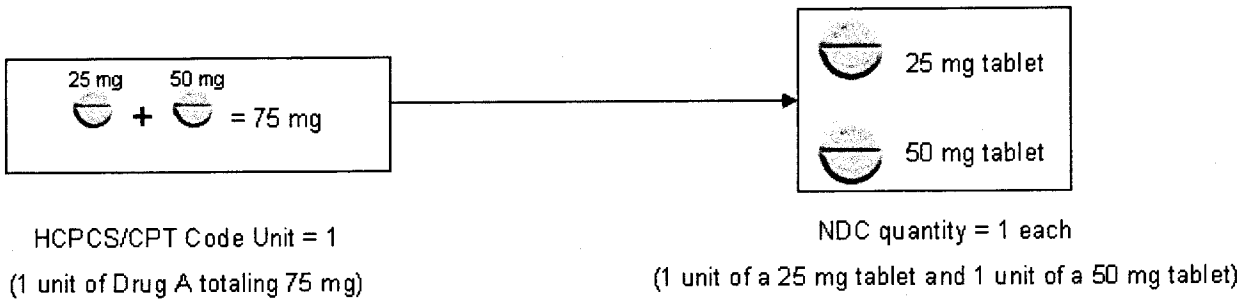
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

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

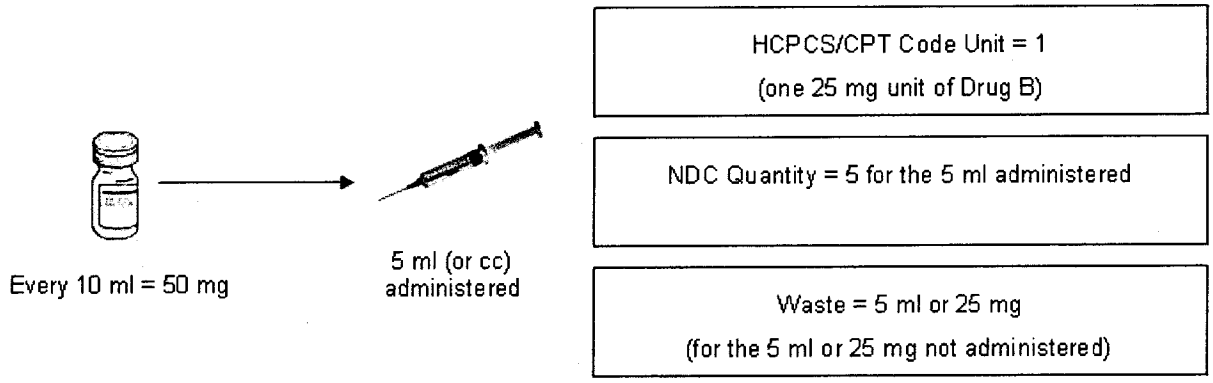
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

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.

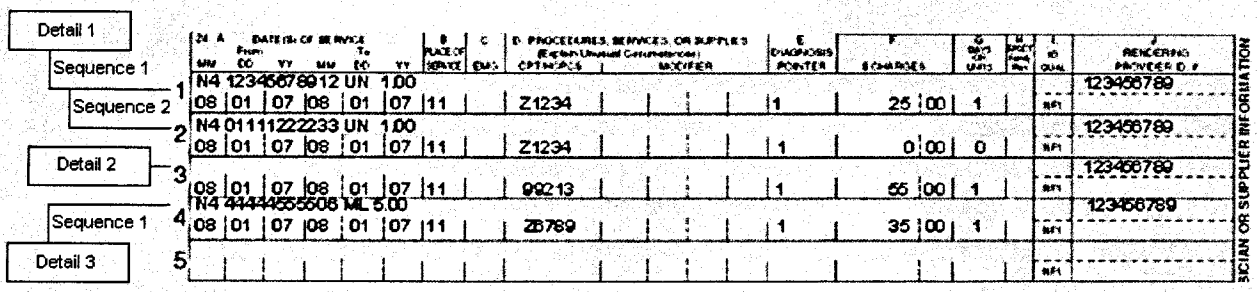
For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

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



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 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Physician/Independent Lab/CRNA/Radiation Therapy Center**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal PHYSICN-4-15**

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

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.

Dawn Stehle
Director

TOC not required

292.910 National Drug Codes (NDCs) 11-1-15

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	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	

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 (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 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.

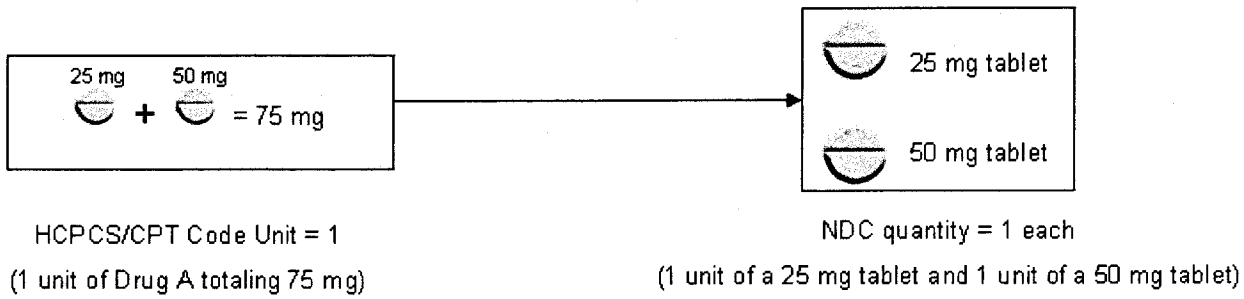
Exception: There is no requirement for an NDC when billing for vaccines radiopharmaceuticals and allergen immunotherapy.

II. Claims Filing

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

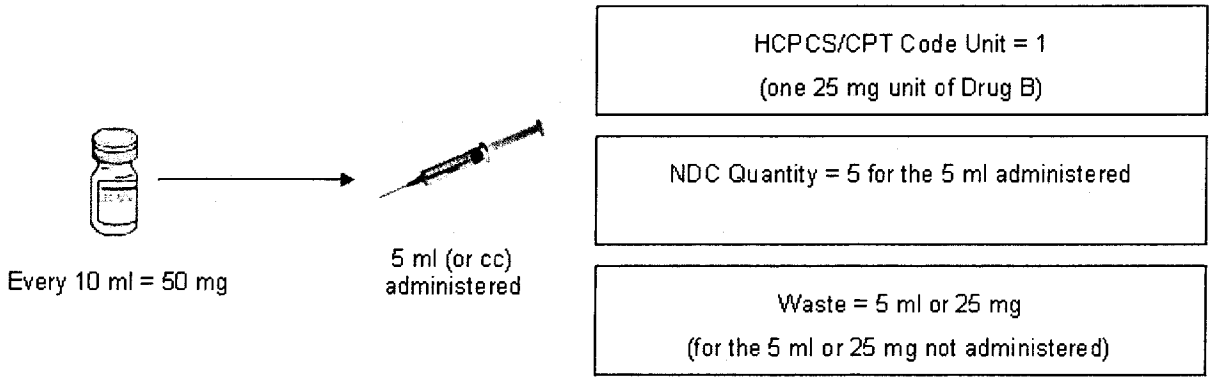
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

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.

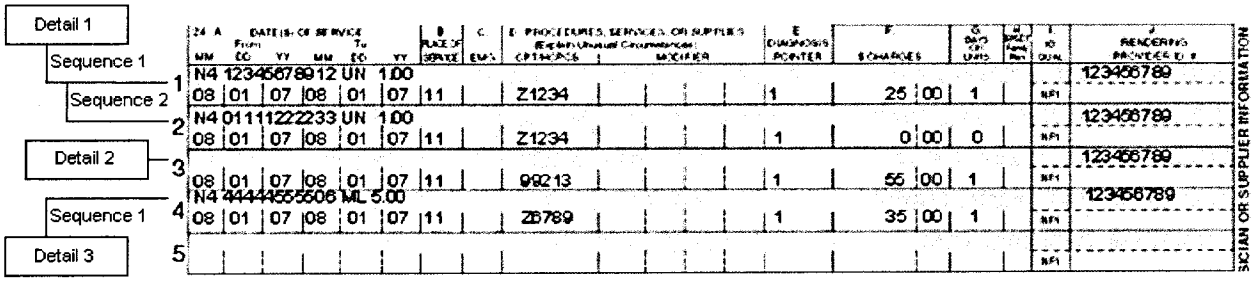
For professional claims, CMS-1500, list the qualifier of "N4", the 11-digit NDC, the unit of measure qualifier (F2 – International Unit; GR – Gram; ML – Milliliter; UN – Unit) and the

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



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.

See Section 292.950 for additional information regarding drug code billing.

292.950 Injections, Therapeutic and/or Diagnostic Agents 11-1-15

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. **View a 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.
2. 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**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
    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 **fifth** 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 **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** 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. **View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services**.

*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
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 (**View ICD Codes.**). 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

*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 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 multi-agent 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 **and** 285.1 **or** 585.1-585.9	No	No	No	No

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 anti-rheumatic 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

*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
J0150	No	No	No	No	No	No	No
NOTE: Maximum 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: 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 1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1-proteinase 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 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
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.							
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).
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
J0585	No	No	No	No	Yes	No	No
NOTE: Botox A is reviewed for medical necessity based on ICD diagnosis code.							
J0586	No	No	No	No	Yes	No	No
NOTE: This procedure code is reviewed for medical necessity based on an ICD diagnosis code billed.							
J0588	No	18y & up	No	No	Yes	No	No
NOTE: An ICD diagnosis code which supports medical necessity is required.							
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).
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
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.							
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.
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**.

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).
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 I	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 (View ICD Codes.) (primary) with (View ICD Codes.) (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 ICD Codes.	Chronic Hepatitis C without mention of coma
	View ICD Codes.	Myelodysplastic
	View ICD Codes.	Rheumatoid Arthritis

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 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 procedure code J0881 in this section for specific criteria.							
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 non-metastatic 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 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
J1050	^	10y & up	^	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.
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 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
J1557	No	2y & up	No	No	Yes	No	No
NOTE: An ICD diagnosis code that supports medical necessity is required.							
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 reviewed for medical necessity based on the ICD diagnosis code billed.							
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.							
J1568	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.							
J1569	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis 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 reviewed for medical necessity based on the ICD diagnosis 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 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
J1602*	No	18y & up	556.0-556.9 696.0 714.0-714.9 721.9	No	Yes	No	Yes

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.
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 (**View ICD Codes.**) as the primary detail diagnosis AND a secondary diagnosis of (**View ICD Codes.**).

The following ICD diagnosis code (**View ICD Codes.**) 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).
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
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
NOTE: The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the Prior Approval Letter.							
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A Prior Approval Letter is required for a diagnosis other than a List 003 diagnosis.							
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 Codes.** 274.00-274.03 or 274.9	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.							

*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
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 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
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
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (**View ICD Codes.**) on the claim.							
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (**View ICD Codes.**) on the 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
NOTE: This procedure code is indicated for a diagnosis of Type 1 Gaucher Disease. A complete history and physical exam with a complete evaluation by a geneticist is required each year. This exam must include the prognosis and all abnormalities associated with Gaucher Disease.							
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

*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
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).
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
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.							
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 code J3465 is covered for non-pregnant beneficiaries.							
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 **or** 733.90	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
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
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 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
J7300	FP	No	No	No	No	No	No
NOTE: Procedure code J7300 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7301	FP	10y & up	No	No	No	No	No
NOTE: Procedure code J7301 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7302	No	No	617.0-617.9 627.2 627.8 **or** 627.9	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.							
J7302	FP	No	No	No	No	No	No
NOTE: Procedure code J7302 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7303	FP	No	No	No	No	No	No
NOTE: Procedure code J7303 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7306	FP	No	No	No	No	No	No
NOTE: Procedure code J7306 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7307	FP	No	No	No	No	No	No
NOTE: Procedure code J7307 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7308	No	No	No	003	No	No	No
J7310	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
J7312*	No	18y & up	**View ICD Codes.** 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 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	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 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
J7330	No	No	No	No	No	Yes	No
NOTE: Procedure code J7330 requires prior authorization from AFMC for all providers. See Sections 260.000, 261.000, 261.100 and 261.110.							
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
NOTE: For consideration, procedure code J7525 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.							
J7527	No	18y & up	**View ICD Codes.**	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.							
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	**View ICD Codes.**	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 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
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	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 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
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.

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.
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
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
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.
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: Requires ICD diagnosis code for cancer or ICD diagnosis 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 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
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.

J9600	No	No	No	003	No	No	No
J9999	No	No	No	003	Yes	No	No

NOTE: See Section 292.950 B for coverage information.

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 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
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 represents "Ondansetron 1 mg, oral" billable electronically or on paper.							
Q0166	UB	No	No	003	No	No	No
NOTE: Use UB modifier for Q0166 –"Granistron HCl tab1mg, oral" (**Kytril**). This is the Arkansas Medicaid description.							
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 billed with manufacturer's invoice attached.							
Q4145*	No	No	No	No	No	No	No
NOTE: Must be billed with manufacturer's invoice 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	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: Procedure code Z1847 is for Torecan 10 mg oral tablets. Limit of (4) 10 mg tabs per day.							
90284	No	No	No	No	Yes	No	No
NOTE: 90284 will be approved for payment based on diagnosis code that proves medical necessity.							
90375*	No	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.							

*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
90376*	No	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.							
90385	No	No	No	No	No	No	No
NOTE: Procedure code 90385 is limited to one injection per pregnancy.							
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE: Indicate dose and attach manufacturer's invoice.							
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 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
90654	EP, TJ	18y-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.							
90654	TJ	18y-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.							
90654	No	19y – 64y	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.							
90655	EP, TJ	6m - 35m	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90655	TJ	6m - 35m	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90656	EP, TJ	3y – 18y	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90656	TJ	3y – 18y	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90656	No	19y & up	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90657	EP, TJ	6m - 35m	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90657	TJ	6m - 35m	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90657	No	19y & up	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90658	EP, TJ	3y – 18y	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90658	TJ	3y – 18y	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90658	No	19y & up	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							

*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
90660	EP, 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.							
90660	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.							
90660	No	19y – 49y	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.							
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 is billable for healthy individuals who are not pregnant. See Subsections A through D of this section for additional instructions.							
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 is billable for healthy individuals who are not pregnant. See Subsections A through D of this section for additional instructions.							
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 code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.							

*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
90676*	No	No	No	No	No	No	No
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.							
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 Subsections A through D of this section for additional instructions.							
90685	TJ	6m – 35m	No	No	No	No	No
NOTE: See Subsections A through D of this section for additional instructions.							
90686	EP, TJ	3y – 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.							
90686	TJ	3y – 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.							
90686	No	19y – 99y	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.							
90688	EP, TJ	3y – 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.							
90688	TJ	3y – 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.							
90688	No	19y & up	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.							
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 – 6y	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 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
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: Submit 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: Submit manufacturer's invoice.							
90727*	No	No	No	No	No	No	No
NOTE: Submit manufacturer'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.
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
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
NOTE: Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.							
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: Zoster vaccine is benefit limited 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
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
NOTE: Claim forms for procedure code 90749 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							
96379*	No	No	No	No	No	No	No
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							

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 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.
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 **fifth** 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 **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** 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. **View contact information for the Medical Director for Clinical Affairs for the Division of Medical Services.**

*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
A9580*	No	No	**View ICD Codes.**	No	No	No	No
NOTE: Procedure code A9580 is payable for beneficiaries with a primary diagnosis of (**View ICD Codes.**). 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
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
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
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 multi-agent 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).
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
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 Imiglucerase, 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 anti-rheumatic 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
J0150	No	No	No	No	No	No	No
NOTE: Maximum units allowed are 4 per day.							
J0152	No	No	No	No	No	No	No
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.
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.							
J0180*	No	No	**View ICD Codes.**	No	No	No	Yes
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.							
J0256	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.
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 1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha 1-proteinase 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.							
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
J0456	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
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 reviewed for medical necessity based on ICD diagnosis code.

J0586	No	No	No	No	Yes	No	No

NOTE: This procedure code is reviewed for medical necessity based on an ICD diagnosis code billed.

J0588	No	18y & up	No	No	Yes	No	No

NOTE: An ICD diagnosis code which supports medical necessity is required.

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.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0597*	No	13y & up	View ICD Codes.	No	No	No	No
NOTE: This code will be reviewed for medical necessity based on the clinical documentation submitted.							
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
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.
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

*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
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

  - 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).
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

*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 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 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 (View ICD Codes.) (primary) with (View ICD Codes.) (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 ICD Codes.	Chronic Hepatitis C without mention of coma
	View ICD Codes.	Myelodysplastic
	View ICD Codes.	Rheumatoid Arthritis

J0882	No	No	View ICD Codes.	No	No	No	No
J0885							

*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
NOTE: See procedure code J0881 in this section for specific criteria.							
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 non-metastatic 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 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
J1050	^	10y & up	^	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.
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: An ICD diagnosis code that supports medical necessity is required.

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.
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
J1560	No	No	No	No	No	No	No
J1561	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.							
J1562	No	No	No	No	No	No	No
J1566	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.							
J1568	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis code billed.							
J1569	No	No	No	No	Yes	No	No
NOTE: Claims are reviewed for medical necessity based on the ICD diagnosis 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 reviewed for medical necessity based on the ICD diagnosis 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 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
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 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 (View ICD Codes.) as the primary detail diagnosis AND a secondary diagnosis of (View ICD Codes.).

The following ICD diagnosis code (View ICD Codes.) 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).
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
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	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 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
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
NOTE: The history and physical showing a relapse of multiple sclerosis must be submitted with the request for the Prior Approval Letter.							
J2353*	No	No	No	003	Yes	No	Yes
J2354*	No	No	No	003	Yes	No	Yes
NOTE: A Prior Approval Letter is required for a diagnosis other than a List 003 diagnosis.							
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 (View ICD Codes.). Diagnosis codes must be shown on the claim form.							
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).
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
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).
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
J2993	No	No	No	No	No	No	No
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (View ICD Codes.) on the claim.							
J2995	No	No	No	003	No	No	No
J2997	No	No	No	No	No	No	No
NOTE: Limited to 4 units per day in the office place of service for the purpose of declotting catheters. Bill ICD diagnosis (View ICD Codes.) on the 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
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.
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.

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 code J3465 is covered for non-pregnant beneficiaries.

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.
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: Procedure code J3487 is valid with a primary ICD diagnosis of (View ICD Codes.).							
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 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
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.							
J7300	FP	No	No	No	No	No	No
NOTE: Procedure code J7300 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7302	FP	No	No	No	No	No	No
NOTE: Procedure code J7302 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7303	FP	No	No	No	No	No	No
NOTE: Procedure code J7303 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7306	FP	No	No	No	No	No	No
NOTE: Procedure code J7306 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
J7307	FP	No	No	No	No	No	No
NOTE: Procedure code J7307 requires modifier FP and is billable by a non-hospital based physician. See Section 292.551 for detailed billing information.							
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).
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
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.

J7330	No	No	No	No	No	Yes	No

NOTE: Procedure code J7330 requires prior authorization from AFMC for all providers. See Sections 260.000, 261.000, 261.100 and 261.110.

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.
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
J7525*	No	No	No	No	Yes	No	No
NOTE: For consideration, procedure code J7525 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.							
J7527	No	18y & up	**View ICD Codes.**	No	No	No	No
J7599*	No	No	No	No	No	No	No
NOTE: For consideration, procedure code J7599 must be billed on a paper claim form with the name of the drug, dosage and the route of administration.							
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 Codes.	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 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
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).
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
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 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	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 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
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: Requires ICD diagnosis code for cancer or ICD diagnosis 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
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
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.
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: See Section 292.950 B for coverage information.							
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: QO162-UB represents "Ondansetron 1 mg, oral" billable electronically or on paper.							
Q0166	UB	No	No	003	No	No	No
NOTE: Use UB modifier for Q0166 –"Granistron HCl tab1mg, oral" (**Kytril**). This is the Arkansas Medicaid description.							
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.
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
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: Procedure code Z1847 is for Torecan 10 mg oral tablets. Limit of (4) 10 mg tabs 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.
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
90284	No	No	No	No	Yes	No	No
NOTE: 90284 will be approved for payment based on diagnosis code that proves medical necessity.							
90375*	No	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.							
90376*	No	No	No	No	No	No	No
NOTE: Each date of service must be billed on a separate detail. The manufacturer's invoice must be attached along with the clinical administration records indicating medical necessity, dosage, anatomical site and route of administration. Reimbursement rate includes administration fee.							
90385	No	No	No	No	No	No	No
NOTE: Procedure code 90385 is limited to one injection per pregnancy.							
90386	No	No	No	No	No	No	No
90581*	No	18y & up	No	No	No	No	No
NOTE: Indicate dose and attach manufacturer's invoice.							
90632	No	19y & up	No	No	No	No	No
90662	No	65y & up	No	No	No	No	No
NOTE: Procedure code 90662 is covered for beneficiaries ages 65 years and older for dates of service on or after October 11, 2010.							
90675*	No	No	No	No	No	No	No
NOTE: Procedure code 90675 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.							
90676*	No	No	No	No	No	No	No
NOTE: Procedure code 90676 is covered for all ages without diagnosis restrictions. Billing requires paper claims with procedure code and dosage entered in Field 24D of claim form CMS-1500 for each date of service. If date spans are used, appropriate units of service must be indicated and must be identified for each date within the span. The manufacturer's invoice must be attached. Reimbursement rate includes administration fee.							
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
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	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: Submit invoice with claim.							
90719	No	No	No	No	No	No	No
90725*	No	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.							
90727*	No	No	No	No	No	No	No
NOTE: Submit manufacturer's invoice.							
90732	No	2y & up	No	No	No	No	No
NOTE: Patients age 21 years and older who receive the injection must be considered by the provider as high risk. All beneficiaries over age 65 may be considered high risk.							
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
NOTE: Claim forms for procedure code 96379 should be submitted with a description of the service provided (drug, dose, route of administration) as well as clinical notes describing the procedure including documentation of medical necessity.							

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Prosthetics**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal PROSTHET-5-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	242.401	11-1-15
—	—	242.402	11-1-15

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) 11-1-15

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 CODE	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	

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 (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 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.

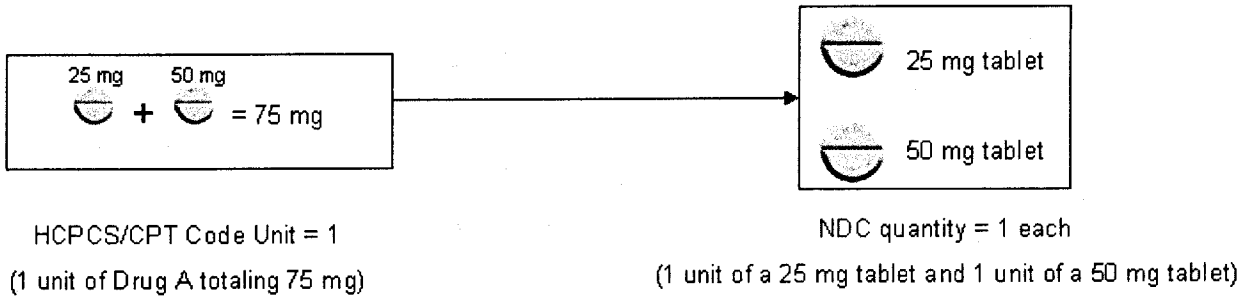
II. Claims Filing

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

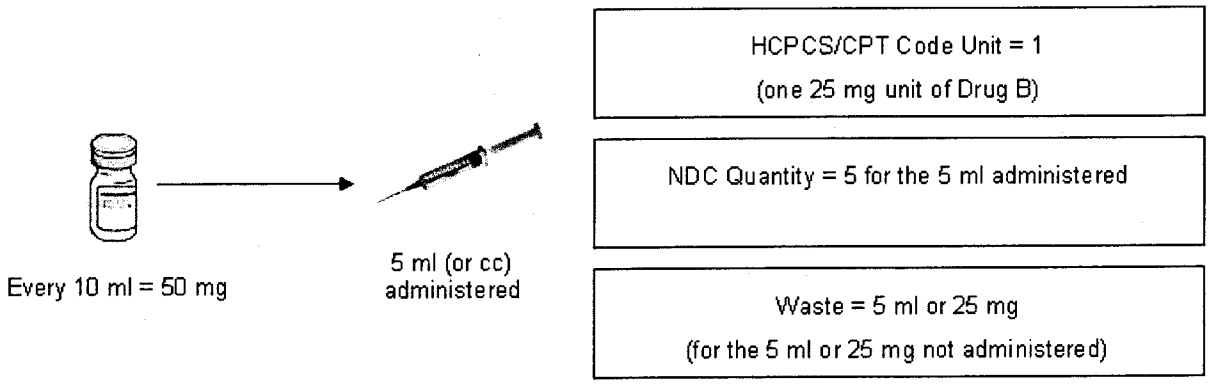
example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

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.

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.

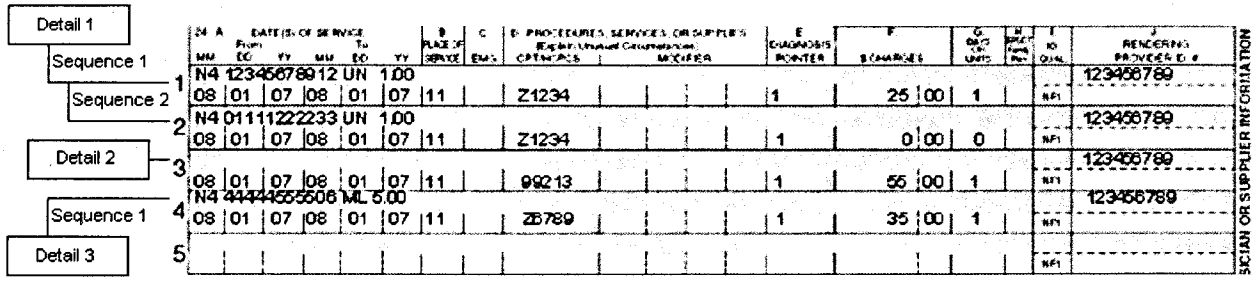
See Diagram 6 for CMS-1500.

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



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

242.402 Billing of Multi-Use and Single-Use Vials 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: Arkansas Medicaid Health Care Providers – Rural Health Clinic

DATE: November 1, 2015

SUBJECT: Provider Manual Update Transmittal RURLHLTH-2-15

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
—	—	252.103	11-1-15

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
Director

TOC required

252.103 Billing of Multi-Use and Single-Use Vials 11-1-15

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.
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 units administered to the beneficiary.
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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

TO: **Arkansas Medicaid Health Care Providers – Transportation**

DATE: **November 1, 2015**

SUBJECT: **Provider Manual Update Transmittal TRANSP-1-15**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
252.100	12-2-11	252.100	11-1-15
252.110	12-2-11	252.110	11-1-15

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.

Dawn Stehle
Director

TOC not required

252.100 Ambulance Procedure Codes 11-1-15

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.

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.
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 units administered to the beneficiary.
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.

Procedure Code	Required Modifier	Description
A0422	U1	Emergency, oxygen, helicopter air ambulance
A0425		Ground mileage per statute mile

Procedure Code	Required Modifier	Description
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

11-1-15

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

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 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 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.

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

HCPCS/CPT Code Unit = 1

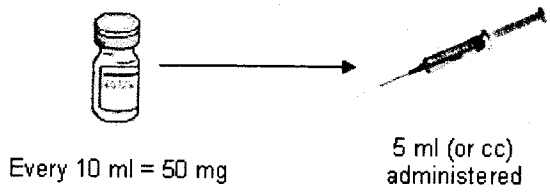
(1 unit of Drug A totaling 75 mg)

NDC quantity = 1 each

(1 unit of a 25 mg tablet and 1 unit of a 50 mg tablet)

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



HCPCS/CPT Code Unit = 1
(one 25 mg unit of Drug B)

NDC Quantity = 5 for the 5 ml administered

Waste = 5 ml or 25 mg
(for the 5 ml or 25 mg not administered)

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.

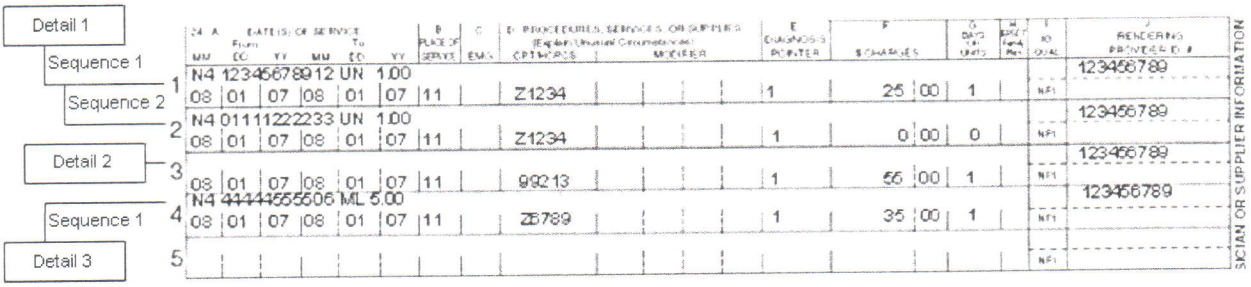
CMS-1500

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



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.