ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

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## NOTICE OF RULE MAKING

**TO:** **Health Care Providers – Ambulatory Surgical Center, Area Health Education Centers (AHECs), ARKids First-B, Critical Access Hospital, Dental, Home Health, End-Stage Renal Disease, Hospital, Independent Radiology, Nurse Practitioner, Physician, Podiatrist, Prosthetics, Rehabilitative Hospital and Transportation**

**DATE:** **December 18, 2015**

**SUBJECT:** **2015 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion**

### I. General Information

A review of the 2015 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedural Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after December 18, 2015. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2015 HCPCS Level II will become non-payable for dates of service on and after December 18, 2015.

**Please NOTE: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2015 CPT and HCPCS conversions.**

### II. 2015 HCPCS Payable Procedure Codes Tables Information

Procedure codes are in separate tables. Tables are created for each affected provider type (i.e., prosthetics, home health, etc.).

The tables of payable procedure codes for all affected programs are designed with eight columns of information. All columns may not be applicable for each covered program, but are devised for ease of reference.

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

1. The first column of the list contains the HCPCS procedure codes. The procedure code may be on multiple lines on the table, depending on the applicable modifier(s) based on the service performed.

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

3. The third column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years.

4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD diagnosis range. This information is used, for example, by physicians and hospitals. The fourth column, for all affected programs, indicates the beginning and ending range of ICD CM diagnoses for which a procedure code may be used.

5. The fifth column contains information about the diagnosis list for which a procedure code may be used. (See Section V of this notice for more information about diagnosis range and lists.)

6. The sixth column indicates whether a procedure is subject to medical review before payment. The column is titled "Review." The word "Yes" or "No" in the column indicates whether a review is necessary or not. Providers should consult their program manual to obtain the information that is needed for a review.

7. The seventh column shows procedure codes that require prior authorization (PA) before the service may be provided. The column is titled "PA." The word "Yes" or "No" in the column indicates if a procedure code requires prior authorization. Providers should consult their program manual to ascertain what information should be provided for the prior authorization process.

8. The eighth column indicates a procedure code requires a prior approval letter from the Arkansas Medicaid Medical Director for Clinical Affairs for the Division of Medical Services. The word "Yes" or "No" in the column indicates if a procedure code requires a prior approval letter.

## III. Acquisition of Prior Approval Letter

A prior approval letter, when required, must be attached to a paper claim when it is filed. Providers must obtain prior approval in accordance with the following procedures for special pharmacy, therapeutic agents and treatments:

A. Process for Acquisition: Before treatment begins, the Medical Director for Clinical Affairs in the Division of Medical Services (DMS) must approve any drug, therapeutic agent or treatment not listed as covered in a provider manual or in official DMS correspondence. This requirement also applies to any drug, therapeutic agent or treatment with a prior approval letter indicated for coverage in a provider manual or official DMS correspondence.

B. The Medical Director for Clinical Affairs' review is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

1. The provider must submit a history and physical examination with the treatment plan before beginning any treatment.

2. The provider will be notified by mail of the DMS Medical Director for Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each paper claim submission.

   **Any change in approved treatment requires resubmission and a new prior approval letter.**

3. Requests for a prior approval letter must be addressed to the attention of the Medical Director for Clinical Affairs. Contact the Medical Director for Clinical Affairs' office for any additional coverage information and instructions.

| | |
|---|---|
| Mailing address:<br>Attention:<br>Arkansas Medicaid Medical Director<br>for Clinical Affairs<br>1020 West 4th Street, Suite 300<br>Little Rock, AR 72201 | Fax: 501-212-8741<br>Phone: 501-212-8663 |

## IV. Process for Obtaining Prior Authorization

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

| | |
|---|---|
| In-state and out-of-state toll free for inpatient reviews, prior authorizations for surgical procedures and assistant surgeons only | 1-800-426-2234 |
| General telephone contact, local or long distance – Fort Smith | (479) 649-8501<br>1-877-650-2362 |
| Fax for CHMS only | (479) 649-0776 |
| Fax for Molecular Pathology only | (479) 649-9413 |
| Fax | (479) 649-0799 |
| Web portal | http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx |
| Mailing address | Arkansas Foundation for Medical Care, Inc.<br>P.O. Box 180001<br>Fort Smith, AR 72918-0001 |
| Physical site location | 5111 Rogers Avenue, Suite 476<br>Fort Smith, AR 72903 |
| Office hours | 8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays |

## V. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. **Diagnosis list 103** is specified here (**View ICD Codes.**). For any other diagnosis restrictions, reference the table for each individual program.

## VI. Dental

The following 2015 ADA Dental procedure codes **are not covered** by Arkansas Medicaid.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| D0171 | D0351 | D1353 | D6110 | D6111 | D6112 | D6113 | D6114 |
| D6115 | D6116 | D6117 | D6549 | D9219 | D9931 | D9986 | D9987 |

## VII. HCPCS Procedure Codes Payable to End-Stage Renal Disease Providers

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

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J0887 | No | 21y & up | Yes; see below | No | No | No | No |

NOTE: The primary diagnosis should be (**View ICD Codes.**) with a secondary diagnosis of (**View ICD Codes.**). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J0888 | No | 21y & up | **View ICD Codes.** | No | No | No | No |

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

## VIII. HCPCS Procedure Codes Payable to Home Health Providers

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

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J0887 | No | 21y & up | Yes; see below | No | No | No | No |

NOTE: The primary diagnosis should be (**View ICD Codes.**) with a secondary diagnosis of (**View ICD Codes.**). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J0888 | No | 21y & up | **View ICD Codes.** | No | No | No | No |

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

## IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| C9025 | No | 18y & up | No | 103 | No | No | No |
| C9026 | No | 18y & up | **View ICD Codes.** | No | Yes | No | Yes |
| NOTE: **Entyvio** is an integrin receptor antagonist for adult ulcerative colitis (UC). For adults with UC it must be moderately to severely active and have had an inadequate response with, or lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) inducing and maintaining clinical response; 2) inducing and maintaining clinical remission; 3) improving endoscopic appearance of the mucosa; or 4) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. For adults with Crohn's disease, it must be moderately to severely active with an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) achieving clinical response; 2) achieving clinical remission; or 3) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. Physician must submit a history and physical exam with the Prior Approval Letter to the Medical Director for Clinical Affairs. | | | | | | | |
| C9027 | No | 18y & up | Yes | 103 | Yes | No | Yes |
| NOTE: **Keytruda** is a human programmed death receptor-1 (PD-1)-blocking antibody indicated for the treatment of patients with unresectable or metastatic melanoma (**View ICD Codes.**) and disease progression following **ipilimumab** and, if BRAF V600 mutation positive, a BRAF inhibitor, in adult patients. The maximum dose is 2mg/kg. There will not be approvals for over this dose. If the patient is on high dose corticosteroids, **Keytruda** should be discontinued. If the patient has disease progression, **Keytruda** should be discontinued. Medical records documenting a history and physical exam showing use of **ipilimumab** first or a BRAF inhibitor should be forwarded to the Medical Director for Clinical Affairs. The patient should have a prognosis of 6 months. All treatments should be included in the medical records. Prior surgeries or other chemotherapeutics should be documented. A letter of Prior Approval will be approved for the length of treatment. | | | | | | | |
| C9136 | No | No | **View ICD Codes.** | No | No | No | No |
| C9349 | No | No | No | No | No | No | No |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| C9442 | No | 18y & up | View ICD Codes. | No | Yes | No | Yes |
| NOTE: **Beleodaq** is a histone decacetylase inhibitor indicated for the treatment of adult patients with relapsed or refractory peripheral T-cell lymphoma (PTCL). All previous treatments should be documented. A complete history and physical exam documenting previous treatments and results should be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter. Length of treatment should be specified. | | | | | | | |
| C9443 | No | 18y & up | No | No | No | No | No |
| C9444 | No | 18y & up | No | No | No | No | No |
| C9446 | No | 18y & up | No | No | No | No | No |
| C9739 | No | No | No | No | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| C9740 | No | No | No | No | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| G6015 | No | No | No | No | No | No | No |
| J0153 | No | No | No | No | No | No | No |
| J0887 | No | 21y & up | Yes; see below | No | No | No | No |
| NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:<br>• Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.<br>• If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.<br>• The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.<br>• Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary. | | | | | | | |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J0888 | No | 21y & up | View ICD Codes. | No | No | No | No |

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J1071 | No | No | No | View ICD Codes. | No | No | No |
| J1439 | No | 18y & up | View ICD Codes. | No | No | No | No |
| J2274 | No | No | No | No | No | No | No |
| J2704 | No | 3y & up | No | No | No | No | No |
| J3121 | No | No | No | 103 | No | No | No |

NOTE: Covered for males only.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J3145 | No | No | No | 103 | No | No | No |

NOTE: Covered for males only.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J7181 | No | No | View ICD Codes. | No | No | No | No |
| J7201 | No | No | No | No | No | No | No |
| J7327 | No | 18y & up | 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, J7325 and J7327. 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 the Utilization Review prior authorization information in the provider manual. 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.

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J9267 | No | No | No | 103 | No | No | No |
| J9301 | No | 18y & up | View ICD Codes. | No | Yes | No | Yes |
| NOTE: **Gazyva** is a CD-20 directed cytolytic antibody and is indicated, in combinations with chlorambucil, for the treatment of adult patients with previously untreated chronic lymphocytic leukemia. Patients should have a protocol with chlorambucil and a history and physical exam covering all treatments including failures to submit to the Medical Director for Clinical Affairs for a Prior Approval Letter. Dates of Service need to be included. | | | | | | | |
| Q4150 | No | No | No | No | No | No | No |
| Q4152 | No | No | No | No | No | No | No |
| Q4157 | No | No | No | No | No | No | No |
| Q4160 | No | No | No | No | No | No | No |

## X. HCPCS Procedure Codes Payable to Independent Radiology

The following information is related to procedure codes payable to Independent Radiology providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| G6015 | No | No | No | No | No | No | No |

## XI. HCPCS Procedure Codes Payable to Nurse Practitioners

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

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| G6015 | No | No | No | No | No | No | No |
| J0887 | No | 21y & up | Yes; see below | No | No | No | No |

NOTE: The primary diagnosis should be (**View ICD Codes.**) with a secondary diagnosis of (**View ICD Codes.**). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J0888 | No | 21y & up | **View ICD Codes.** | No | No | No | No |

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| J3121 | No | No | No | 103 | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| J3145 | No | No | No | 103 | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| J9267 | No | No | No | 103 | No | No | No |

## XII. HCPCS Procedure Codes Payable to Physicians and Area Health Education Centers (AHECs)

The following information is related to procedure codes payable to Physician and AHEC providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| C9025 | No | 18y & up | No | 103 | No | No | No |
| C9026 | No | 18y & up | View ICD Codes. | No | Yes | No | Yes |
| NOTE: **Entyvio** is an integrin receptor antagonist for adult ulcerative colitis (UC). For adults with UC it must be moderately to severely active and have had an inadequate response with, or lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) inducing and maintaining clinical response; 2) inducing and maintaining clinical remission; 3) improving endoscopic appearance of the mucosa; or 4) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. For adults with Crohn's disease, it must be moderately to severely active with an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) achieving clinical response; 2) achieving clinical remission; or 3) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. Physician must submit a history and physical exam with the Prior Approval Letter to the Medical Director for Clinical Affairs. | | | | | | | |
| C9027 | No | 18y & up | Yes | 103 | Yes | No | Yes |
| NOTE: **Keytruda** is a human programmed death receptor-1 (PD-1)-blocking antibody indicated for the treatment of patients with unresectable or metastatic melanoma (View ICD Codes.) and disease progression following **ipilimumab** and, if BRAF V600 mutation positive, a BRAF inhibitor, in adult patients. The maximum dose is 2mg/kg. There will not be approvals for over this dose. If the patient is on high dose corticosteroids, **Keytruda** should be discontinued. If the patient has disease progression, **Keytruda** should be discontinued. Medical records documenting a history and physical exam showing use of **ipilimumab** first or a BRAF inhibitor should be forwarded to the Medical Director for Clinical Affairs. The patient should have a prognosis of 6 months. All treatments should be included in the medical records. Prior surgeries or other chemotherapeutics should be documented. A letter of Prior Approval will be approved for the length of treatment. | | | | | | | |
| C9136 | No | No | View ICD Codes. | No | No | No | No |
| C9349 | No | No | No | No | No | No | No |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| C9442 | No | 18y & up | View ICD Codes. | No | Yes | No | Yes |
| NOTE: **Beleodaq** is a histone decacetylase inhibitor indicated for the treatment of adult patients with relapsed or refractory peripheral T-cell lymphoma (PTCL). All previous treatments should be documented. A complete history and physical exam documenting previous treatments and results should be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter. Length of treatment should be specified. | | | | | | | |
| C9443 | No | 18y & up | No | No | No | No | No |
| C9444 | No | 18y & up | No | No | No | No | No |
| C9446 | No | 18y & up | No | No | No | No | No |
| C9739 | No | No | No | No | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| C9740 | No | No | No | No | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| G6015 | No | No | No | No | No | No | No |
| J0153 | No | No | No | No | No | No | No |
| J0887 | No | 21y & up | Yes; see below | No | No | No | No |
| NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:<br>• Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.<br>• If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.<br>• The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.<br>• Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary. | | | | | | | |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J0888 | No | 21y & up | View ICD Codes. | No | No | No | No |
| NOTE: For patients with CKD **not on dialysis**:<br>• Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:<br>  • The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and<br>  • Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.<br>• If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions. | | | | | | | |
| J1071 | No | No | No | 103 | No | No | No |
| J1439 | No | 18y & up | View ICD Codes. | No | No | No | No |
| J2274 | No | No | No | No | No | No | No |
| J3121 | No | No | No | 103 | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| J3145 | No | No | No | 103 | No | No | No |
| NOTE: Covered for males only. | | | | | | | |
| J7181 | No | No | View ICD Codes. | No | No | No | No |
| J7201 | No | No | No | No | No | No | No |
| J7327 | No | 18y & up | 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, J7325 and J7327. 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 the Utilization Review prior authorization information in the provider manual. 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. | | | | | | | |
| J9267 | No | No | No | 103 | No | No | No |

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J9301 | No | 18y & up | View ICD Codes. | No | Yes | No | Yes |
| NOTE: **Gazyva** is a CD-20 directed cytolytic antibody and is indicated, in combinations with chlorambucil, for the treatment of adult patients with previously untreated chronic lymphocytic leukemia Patients should have a protocol with chlorambucil and a history and physical exam covering all treatments including failures to submit to the Medical Director for Clinical Affairs for a Prior Approval Letter. Dates of Service need to be included. | | | | | | | |
| Q4150 | No | No | No | No | No | No | No |
| Q4152 | No | No | No | No | No | No | No |
| Q4157 | No | No | No | No | No | No | No |
| Q4160 | No | No | No | No | No | No | No |

## XIII. HCPCS Procedure Codes Payable to Podiatrists

The following information is related to procedure codes payable to Podiatrist providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| C9349 | No | No | No | No | No | No | No |
| Q4150 | No | No | No | No | No | No | No |
| Q4152 | No | No | No | No | No | No | No |
| Q4157 | No | No | No | No | No | No | No |
| Q4160 | No | No | No | No | No | No | No |

## XIV. HCPCS Procedure Codes Payable to Prosthetics Providers

The following information is related to procedure codes payable to Prosthetics providers:

Procedure codes in the table must be billed with appropriate modifiers. For procedure codes that require a prior authorization, the written PA request must be submitted to the Utilization Review Section of the Division of Medical Services (DMS) for wheelchairs and wheelchair related equipment and services.

For other durable medical equipment (DME), a written request must be submitted to the Arkansas Foundation for Medical Care. Please refer to your Arkansas Medicaid Prosthetics Provider Manual for details on requesting a DME prior authorization.

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| K0901 | EP | 0-20y | No | No | No | No | No |
| K0901 | No | 21y & up | No | No | No | Yes | No |
| K0902 | EP | 0-20y | No | No | No | No | No |
| K0902 | No | 21y & up | No | No | No | Yes | No |
| L3981 | EP | 0-20y | No | No | No | No | No |
| L3981 | No | 21y & up | No | No | No | No | No |
| L7259 | EP | 0-20y | No | No | No | No | No |
| L7259 | No | 21y & up | No | No | No | Yes | No |

## XV. HCPCS Procedure Codes Payable to Transportation Providers

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

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J0153 | No | No | No | No | No | No | No |

## XVI. Miscellaneous Information

An asterisk (*) after the procedure code denotes the requirement of a paper claim.

A. Existing HCPCS procedure codes **A6208**, **A6250**, **A6266** and **A6457** are payable to Prosthetics and Home Health providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| A6208 | NU | No | No | No | No | No | No |
| A6250 | NU | No | No | No | No | No | No |
| A6266 | NU | No | No | No | No | No | No |
| A6457 | NU | No | No | No | No | No | No |

B. Effective July 1, 2015, for beneficiaries age 21 and over, a benefit limit of $60,000 per State Fiscal Year (July 1 through June 30) has been established for reimbursement for prosthetic devices. When the Medicaid maximum allowable for a prosthetic device item is $1,000 or more, prior authorization is required.

C. ICD code (**View ICD Codes.**) has been added to existing HCPCS procedure code **J0490**. All other criteria remain unchanged:

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

D. Existing HCPCS procedure code **J1446** is now payable to Hospital, Physician, and Nurse Practitioner providers:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J1446 | No | 21y & up | No | No | No | No | No |

E. Existing HCPCS procedure code **J9228** will require ICD diagnosis as listed below in the Diagnosis table:

| 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: **Iplimumab** is indicated for treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function and clinical chemistries must be monitored before each dose. **Iplimumab** 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 **Iplimumab** 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 should be at least 18 years old and have a life expectancy of at least 4 months. It should not be used if patient had previous autoimmune disease requiring systemic therapy. A Prior Approval Letter with a history and physical exam must be sent to the Medical Director of Clinical Affairs.

F. Existing HCPCS procedure code J9047 no longer requires a Prior Approval letter. All other criteria remain unchanged:

| Procedure Code | Modifier | Age Restriction | Diagnosis | Diagnosis List | Review | PA | Prior Approval Letter |
|---|---|---|---|---|---|---|---|
| J9047* | No | 18y & up | **View ICD Codes.** | No | No | No | No |

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.

## XVII. Non-Covered 2015 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2015 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code or a revenue code.

| | | | |
|---|---|---|---|
| A9606 | C2624 | C2644 | C9742 |

## XVIII. Non-Covered 2015 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A4459 | A4602 | A7048 | C9447 | C9741 | G0276 | G0277 | G0279 |
| G0464 | G0466 | G0467 | G0468 | G0469 | G0470 | G0471 | G0472 |
| G0473 | G6001 | G6002 | G6003 | G6004 | G6005 | G6006 | G6007 |
| G6008 | G6009 | G6010 | G6011 | G6012 | G6013 | G6014 | G6016 |
| G6017 | G6018 | G0619 | G0620 | G0621 | G6022 | G6023 | G6024 |
| G6025 | G6027 | G6028 | G6030 | G6031 | G6032 | G6034 | G6035 |
| G6036 | G6037 | G6038 | G6039 | G6040 | G6041 | G6042 | G6043 |
| G6044 | G6045 | G6046 | G6047 | G6048 | G6049 | G6050 | G6051 |
| G6052 | G6053 | G6054 | G6055 | G6056 | G6057 | G6058 | G9362 |
| G9363 | G9364 | G9365 | G9366 | G9367 | G9368 | G9369 | G9370 |
| G9376 | G9377 | G9378 | G9379 | G9380 | G9381 | G9382 | G9383 |
| G9384 | G9385 | G9386 | G9389 | G9390 | G9391 | G9392 | G9393 |
| G9394 | G9395 | G9396 | G9399 | G9400 | G9401 | G9402 | G9403 |
| G9404 | G9405 | G9406 | G9407 | G9408 | G9409 | G9410 | G9411 |
| G9412 | G9413 | G9414 | G9415 | G9416 | G9417 | G9418 | G9419 |
| G9420 | G9421 | G9422 | G9423 | G9424 | G9425 | G9426 | G9427 |
| G9428 | G9429 | G9430 | G9431 | G9432 | G9433 | G9434 | G9435 |
| G9436 | G9437 | G9438 | G9439 | G9440 | G9441 | G9442 | G9443 |
| G9448 | G9449 | G9450 | G9451 | G9452 | G9453 | G9454 | G9455 |
| G9456 | G9457 | G9458 | G9459 | G9460 | G9463 | G9464 | G9465 |
| G9466 | G9467 | G9468 | G9469 | G9470 | G9471 | G9472 | J0571 |
| J0572 | J0573 | J0574 | J0575 | J1322 | J7182 | J7200 | J7336 |
| L6026 | L8696 | Q2052 | Q4151 | Q4153 | Q4154 | Q4155 | Q4156 |
| Q4158 | Q4159 | S1034 | S1035 | S1036 | S1037 | S8032 | S9901 |

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise 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 download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle
Director