ARKANSAS REGISTER

Transmittal Sheet

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Secretary of State
John Thurston
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Mac E. Golden E-mail Mac.E.Golden@dhs.arkansas.gov Phone 501.320.6383

Statutory Authority for Promulgating Rules Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

Rule Title: Medicaid Limits on Lab/Radiology and SPA 2022-0003

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	03/11/2022
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	04/09/2022
☑ Other 07/01/2022 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	05/20/2022
	Adopted by State Agency	07/01/2022

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Renita Jones	Renita.Jones@dhs.arkansas.gov	05/20/2022
Contact Person	E-mail Address	Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

501-244-7944 Elizabeth.Pitman@dhs.arkansas.gov

Phone Number E-mail Address

Director

Title

05/20/2022

Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

TOC required

215.110 Benefit Limits for Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. Both diagnostic laboratory and radiology/other services in all settings, including ASCs, are subject to a benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Magnetic resonance imaging (MRI) services are exempt from the radiology/other services benefit limit per SFY.

C. Individuals under twenty-one (21) years of age are not subject to the diagnostic laboratory services benefit limit or to the radiology/other services benefit limit, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

215.120 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Requests to extend benefits for outpatient visits, diagnostic laboratory services, and radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information for how to obtain information regarding submission processes.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

D. Additional information will be requested as needed to process a benefit extension request. Failures to provide requested additional information within the specified timeline will result in technical denials. Reconsiderations for technical denials are not available.

E. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" Form DMS-671. **View or print form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid procedure code or revenue code, modifier(s) when applicable and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;

2. Be signed by the performing provider;
3. Include clinical, outpatient, or emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical records related to current pregnancy (when applicable); and
7. Include clinical indication for diagnostic laboratory and radiology/other services that are ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Laboratory and radiology/other reports must include*:*

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

212.000 Coverage of Chiropractic Services 7-1-22

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program), except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. Medicaid covers chiropractic services for beneficiaries twenty-one (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year (SFY: July 1 through June 30).
3. Two (2) chiropractic X-rays per SFY are covered by Medicaid. However, an X-ray is not required for treatment.
4. Chiropractic X-rays count against the five-hundred-dollar per SFY radiology/other services benefit limit.

   Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
5. The radiology/other services benefit may be extended when medically necessary (see Section 214.000). All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See **Section III** for instructions on filing joint Medicare/Medicaid claims.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), laboratory services (diagnostic laboratory tests), and

radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services: form (Form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements for Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements include the following:

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include obstetrical record related to current pregnancy; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

242.100 Procedure Codes 7-1-22

The procedure codes for billing chiropractic services are in the link below.

View or print the procedure codes for Chiropractic services.

A. *Authorized procedure codes must be used when filing claims for chiropractic X-rays.

B. Chiropractic X-rays are limited to two (2) per State Fiscal Year (SFY: July 1 through June 30). This service counts against the five-hundred-dollar per SFY (per beneficiary) radiology/other services benefit limit.

C. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

TOC required

213.400 Diagnostic Laboratory and Radiology/Other Services 7-1-22

The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

A. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

B. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

C. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits 7-1-22

A. Medicaid established maximum amounts (benefit limits) for outpatient diagnostic laboratory and for outpatient radiology/other services for clients who are twenty-one (21) years of age or older.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. There are no diagnostic laboratory services benefit limits or radiology/other services benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. There is no benefit limit on professional components of diagnostic laboratory or radiology/other services for hospital inpatient treatment.

D. There is no benefit limit on diagnostic laboratory services related to family planning. (See Section 272.431 for the family-planning-related clinical laboratory procedures.)

E. There is no benefit limit on diagnostic laboratory or radiology/other services performed in conjunction with emergency services in an emergency department of a hospital.

213.420 Diagnostic Laboratory and Radiology/Other Services Referral Requirements 7-1-22

A. A Certified Nurse-Midwife (CNM), referring a Medicaid client for diagnostic laboratory services or radiology/other services must specify a diagnosis code (ICD coding) for each test ordered and include pertinent supplemental diagnoses supporting the need for the test(s) in the order.

1. Reference diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring physicians and CNMs to establish medical necessity.
2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities that are performing the tests.
3. CNMs must follow Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
4. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
5. The following ICD diagnosis codes may not be used for billing. **(View ICD codes).**

B. The following benefit limits apply:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY; and
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

214.100 Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Certified Nurse Midwife (CNM) requests for extension of benefits for clinical, outpatient, diagnostic laboratory, and radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied due to the patient's benefit limits being exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations (of additionally requested information) are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services" form (Form DMS-671). **View or print form DMS-671.**
2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request an extension of benefits for any services with benefit limits, all applicable records (that support the medical necessity of extended benefits) are required.

C. Documentation requirements are as follows.

1. Clinical records *must*:
    a. Be legible and include records supporting the specific request;
    b. Be signed by the performing provider;
    c. Include clinical, outpatient, or emergency room records for relevant dates of service in chronological order;
    d. Include related diabetic and blood pressure flow sheets;
    e. Include a current medication list for the date of service;
    f. Include any obstetrical records related to a current pregnancy (when applicable); and
    g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
    a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
    b. Signed orders for diagnostic laboratory and radiology/other services;
    c. Results signed by the performing provider; and
    d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

220.202 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**

B. The date of the request, and the signature of the provider's authorized representative, are required on the form. Stamped and electronic signatures are accepted.

C. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) encounters, use a separate form for each set of encounters.

D. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

E. Enter the procedure code, modifier(s) (when applicable) and a brief narrative description of the procedure.

F. Enter the number of units (encounters) requested under the extension.

220.203 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and

7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures 7-1-22

A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. The benefit limits apply to claims payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**);
2. HIV infection and AIDS (**View ICD Codes**);
3. Renal failure (**View ICD Codes**);
4. Pregnancy* (**View ICD Codes**): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)

F. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

G. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

H. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and

Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

215.100 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory or X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit a copy of the Medical Assistance Remittance and Status Report that reflects the claim's denial for exhausted benefits with the request. Do not send a claim.

D. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

E. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.101 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," form (Form DMS-671). **View or print Form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.440 CAH Benefit Limits 7-1-22

Inpatient stays, non-emergency outpatient visits, diagnostic laboratory, and radiology/other services in Critical Access Hospitals (CAHs) are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.

Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Benefit-limited services that are received in CAHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

217.141 Computed Tomographic Colonography (CT Colonography) 7-1-22

A. The procedure codes in the link below are covered for computed tomographic (CT) colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical-computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy) and air insufflation to achieve colonic distention.

2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to a neoplasmic or spasmic obstruction, a redundant colon, diverticulitis extrinsic compression, or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized

colon (proximal to the obstruction) would be of use to the surgeons in planning the operative approach to the patient.

3. Limitations:
    a. Virtual colonography is not reimbursable when used for screening or in the absence of any signs indicating symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.
    b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening, or in the absence of signs or symptoms of disease.
    c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (such as a biopsy) or for treatment (such as a polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even if performed for signs or symptoms of disease.
    d. CT colonography procedure codes are counted against the beneficiary's benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) for radiology/other services. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
    e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.
    f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. ICD codes must be coded to the highest level of specificity or claims submitted with those ICD codes will be denied;
2. The results of an instrument/fiberoptic colonoscopy that was performed before the virtual colonoscopy (CT colonography), if the virtual colonoscopy (CT colonography) was incomplete, must be retained in the patient's record; and
3. The patient's medical record must include the following and be available upon request:
    a. The order or prescription from the referring physician;
    b. Description of polyps and lesion:
        i. Lesion size for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views, and the type of view employed for measurement should be stated;
        ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon, and cecum);
        iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa);
        iv. Attenuation (soft-tissue attenuation or fat);
    c. Global assessment of the colon (C-RADS categories of colorectal findings):
        i. C0 – Inadequate study
        poor prep (can't exclude > 10 lesions);
        ii. C1 – Normal colon or benign lesions

no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum);

iii. C2 – Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings;

iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number;

v. C4 – Colonic mass, likely malignant;

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 – Inadequate Study limited by artifact;

ii. E1 – Normal exam or anatomic variant;

iii. E2 – Clinically unimportant findings (no work-up needed);

iv. E3 – Likely unimportant findings (may need work-up); for example, incompletely characterized lesions,
such as hypodense renal or liver lesion;

v. E4 – Clinically important findings (work-up needed), such as solid renal or liver mass, aortic aneurysm, adenopathy; and

e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy that was incomplete due to obstruction.

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under twenty-one (21) years of age.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits being exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. With the request, submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be utilized when requesting extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable records that support the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the

provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization.

272.435 Tissue Typing 7-1-22

A. Authorized procedure codes are payable for the tissue typing for both the donor and the receiver.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. The tissue typing is subject to the following benefit limits:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30);
2. Extensions will be considered for beneficiaries who exceed the five-hundred-dollar benefit limit for diagnostic laboratory services; and
3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue-typing diagnostic laboratory procedures to determine a match for an unrelated bone marrow donor.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollar ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or radiology/other services benefit limit for beneficiaries under twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There are no benefit limits on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

E. Benefits may be extended for other conditions documented as medically necessary.

214.900 Procedures for Obtaining Extension of Benefits 7-1-22

A. Nurse practitioners who perform diagnostic laboratory services or radiology/other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request an extension of benefits for diagnostic laboratory services or radiology/other services, use the following procedures.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Requests for extension of benefits for diagnostic laboratory services or radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.920 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services." 7-1-22

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (such as physician's visits or Nurse Practitioner visits), outpatient services (meaning, hospital outpatient visits), diagnostic laboratory services (meaning, laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**
2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG)
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;

d. Include related diabetic and blood pressure flow sheets;

e. Include a current medication list for the date of service;

f. Include the obstetrical record related to a current pregnancy when applicable; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

2. Diagnostic laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

225.100 Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit, each applies to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG).
2. All benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services, for clients twenty-one (21) years of age.

1. There are no laboratory or radiology/other benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. There is no benefit limit on professional components of laboratory or radiology/other services for hospital inpatient treatment.
3. There is no benefit limit on laboratory services related to family planning. See Section 292.552 for the family-planning-related clinical laboratory procedures exempt from the laboratory services benefit limit.
4. There is no benefit limit on laboratory services or radiology/other services performed as emergency services.

C. Extension-of-benefit requests are considered for medically necessary services.

1. Claims with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (**View ICD Codes**);
   b. HIV infection and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (**View ICD OUD Codes**). Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes**).
2. Benefits may be extended for other conditions based on documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

D. Magnetic resonance imaging (MRI) services are exempt from the five-hundred-dollar ($500) outpatient radiology/other benefit limit. Medical necessity for each MRI must be documented in the client's medical record.

E. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) SFY benefit limit (each) for outpatient laboratory services and for radiology/other services. Medical necessity for each procedure must be documented in the client's medical record.

229.100 Extension of Benefits for Diagnostic Laboratory and Radiology/Other, Physician Office, and Outpatient Hospital Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for diagnostic laboratory, radiology/other, physician office, and outpatient services must be submitted to Department of Human Services (DHS) or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

229.110 Completion of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services, and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671**.
2. Instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

229.120 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must*:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, or emergency room records (as applicable) for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include the obstetrical record related to a current pregnancy (when applicable); and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

229.210 Process for Requesting Extended Therapy Services 7-1-22

A. Requests for extended therapy services for clients under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support the request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671 ("Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services") must be utilized when a person is requesting extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the client when a request is denied. Approved requests will be returned to the provider with information specific to the approval.

292.831 Billing for Tissue Typing 7-1-22

A. Authorized procedure codes are payable for tissue typing, both for the donor and the receiver.

B. The tissue typing is subject to the following benefit limit:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30).
2. Extensions will be considered for individuals who exceed the five-hundred-dollar ($500.00) benefit limit for diagnostic laboratory services.
3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue typing procedures to determine a match for an unrelated donor for a bone marrow transplant.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.300 Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. Diagnostic laboratory services and radiology/other services provided by a podiatrist will be included in the benefit limits for outpatient diagnostic laboratory services and outpatient radiology/other services for individuals twenty-one (21) years of age and over.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. There are no benefits limit for individuals under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. Benefit extensions may be granted in cases of documented medical necessity.

D. Section 242.130 contains procedure codes payable for diagnostic laboratory and radiology/other services.

215.000 Extension of Benefits 7-1-22

Benefit extensions may be requested in the following situations:

A. Extension of Benefits for Medical Visits;

1. Extensions of benefits may be requested for medical visits that exceed the two (2) visits per State Fiscal Year (SFY: July 1 through June 30) for individuals twenty-one (21) years of age and over with documented medical necessity provided along with the request.

B. Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services;

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

4. Extension of the benefits limit for diagnostic laboratory and radiology/other services may be granted for individuals twenty-one (21) years of age and over when documented to be medically necessary.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant Neoplasm **(View ICD codes)**;
2. HIV Infection, including AIDS **(View ICD codes)**;
3. Renal failure **(View ICD codes)**;
4. Pregnancy (**View ICD Codes**); and
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes**).

TOC required

214.000 Benefit Limits 7-1-22

A. Payments for portable X-ray services claims are applied to the radiology/other services benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30).

B. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

C. Beneficiaries under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, do not have benefit limits for portable x-ray services.

214.100 Extension of Benefits for Portable X-Ray Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for Portable X-ray services must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for x-ray services.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (diagnostic laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for how to obtain information regarding submission processes.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology Other Services" form (Form DMS-671). **View or print Form DMS-671.**
2. Instructions for accurate completion of Form DMS- 671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements for Extension of Benefits Request 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);
   d. Include related diabetic and blood pressure flow sheets;

e. Include current medication list for the dates of service;

f. Include obstetrical record related to current pregnancy; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

2. Radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

215.120 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests to extend benefits for outpatient rehabilitative hospital visits. diagnostic laboratory services, and radiology/other services must be mailed to DHS or its designated vendor.

View or print contact information for how to submit the request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits must accompany the request for review. Do not send a claim.

D. Additional information needed to process a benefit extension may be requested from the provider. Failures to provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

E. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Consideration of requests for benefit extensions requires correct completion of all fields of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services." **View or print Form DMS-671.**

C. The request date and the signature of the provider's authorized representative are required on the form. Both stamped and electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extension for more than four (4) encounters, use a separate form for each set of encounters.

E. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers, when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include the obstetrical record related to current pregnancy (if applicable); and
7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and

4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests if applicable.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information for how to submit the request.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671 "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number.

TOC required

218.311 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form. (Form DMS-671). **View or print Form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped and electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extension for more than four (4) encounters, use a separate form for each set of encounters.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter the revenue code, modifier(s) when applicable and the applicable nomenclature.

G. Enter the number of units (encounters) requested under the extension.

218.312 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and
7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles, and fetal non-stress tests (if applicable)

TOC not required

216.300 Process for Requesting Extended Therapy Services 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age and adults receiving services in an Adult Developmental Day Treatment (ADDT) must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO). **View or print the QIO contact information.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received by the QIO within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.
4. The QIO will not accept requests sent via electronic facsimile (FAX) or e-mail.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, including credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

TOC required

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits) outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain instructions for submitting the request.

1. Requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**

2. **Instructions for accurate competition of Form DMS-671 (including indication of required attachments) accompany the Form. All forms are listed and accessible in Section V of each provider manual.**

216.220 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:

a. Be legible and include records supporting the specific request;
b. Be signed by the performing provider;
c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
d. Include related diabetic and blood pressure flow sheets;
e. Include current medication list for date of service;
f. Include the obstetrical record related to the current pregnancy; and
g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

2. Diagnostic laboratory and radiology/other reports must include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

3. Other Laboratory and X-Ray Services

Other medically necessary **diagnostic** laboratory **or radiology/other** services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services **benefits** are limited to five hundred dollars ($500) per State Fiscal Year (**SFY,** July 1 – June 30), **and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).**

Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per **SFY diagnostic laboratory services** benefit limit**, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do** not apply to services provided to recipients under twenty-one (21) **years of age** enrolled in the Child Health Services/**Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory **services benefit limit,** and **the five hundred dollars ($500) per SFY radiology/other** services health benefit limit**s: (a)** Malignant neoplasm; **(b)** HIV infection; and **(c)** renal failure. The cost of related **diagnostic** laboratory **services,** and **radiology/other** services will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limits or the five hundred dollars ($500) per SFY radiology/other** services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory services health benefit limit when the diagnosis is for **O**pioid **U**se **D**isorder **(OUD),** and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment **(MAT)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) **diagnostic** laboratory services health benefit limit.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **SFY outpatient diagnostic** laboratory **services benefit limit or the five hundred dollars ($500) per SFY radiology/other** services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other** services health benefit limits.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) **per SFY radiology/other services** benefit limit. Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in **their** place of residence upon the written order of the recipient's physician. **Portable X-ray s**ervices are limited to the following:

a. Skeletal films **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films **that** do not involve the use of contrast media; and
c. Abdominal films **that** do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **SFY**. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary.

3. Other Laboratory and X-Ray Services

Other medically necessary **diagnostic** laboratory **or radiology/other** services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services **benefits** are limited to five hundred dollars ($500) per State Fiscal Year (**SFY,** July 1-June 30), **and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).**

Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per **SFY diagnostic laboratory services** benefit limit**, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do** not apply to services provided to recipients under twenty-one (21) **years of age** enrolled in the Child Health Services/**Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory **services benefit limit,** and **the five hundred dollars ($500) per SFY radiology/other** services health benefit limit**s: (a)** Malignant neoplasm; **(b)** HIV infection; and **(c)** renal failure. The cost of related **diagnostic** laboratory **services** and **radiology/other** services will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit or the five hundred dollars ($500) per SFY radiology/other** services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory services health benefit limit when the diagnosis is for **O**pioid **U**se **D**isorder **(OUD),** and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment **(MAT)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) **diagnostic** laboratory **or radiology/other** services health benefit limits.

(3) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **SFY** outpatient **diagnostic** laboratory **services benefit limit or five hundred dollars ($500) per SFY radiology/other** services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit** or **the recipient's five hundred dollars ($500) per SFY radiology/other** services health benefit limit.

(4) Portable X-Ray Services are subject to the five hundred dollars ($500) **per SFY X-ray services** benefit limit. Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in **their** residence upon the written order of the recipient's physician. **Portable X-ray s**ervices are limited to the following:

a. Skeletal films **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films **that** do not involve the use of contrast media; and
c. Abdominal films **that** do not involve the use of contrast media.

(5) Two (2) chiropractic X-rays are covered per **SFY**. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided