ARKANSAS REGISTER

Transmittal Sheet

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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

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Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Arkansas Medicaid Procedure Code Linking Table Project

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	10/10/2021
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	11/08/2021
☑ Other 02/01/2022 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	12/17/2021
	Adopted by State Agency	02/01/2022

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

Jack Tiner	jack.tiner@dhs.arkansas.gov	01/07/2022
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.)

S. Elizabeth Pitman
Signature

501-244-3044 elizabeth.pitman@dhs.arkansas.gov
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Director
Title

January 7, 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 not required

218.000 Authorization for Services 2-1-22

All Adult Behavioral Health Services for Community Independence receiving Arkansas Medicaid healthcare benefits on a medical Spenddown basis are retrospectively reviewed for medical necessity.

View or print the procedure codes requiring retrospective review for authorization and for ABHSCI services.

240.100 Reimbursement 2-1-22

Reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowable for each procedure.

Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time the service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying that the beneficiary is eligible for Arkansas Medicaid prior to rendering services.

A. Outpatient Services

Fifteen-Minute Units, unless otherwise stated

Adult Behavioral Health Services for Community Independence must be billed on a per unit basis as indicated in the service definition, as reflected in a daily total, per beneficiary, per service.

Time spent providing services for a single beneficiary may be accumulated during a single, 24-hour calendar day. Providers may accumulatively bill for a single date of service, per beneficiary, per Adult Behavioral Health Services for Community Independence service. Providers are not allowed to accumulatively bill for spanning dates of service.

All billing must reflect a daily total, per Adult Behavioral Health Services for Community Independence service, based on the established procedure codes. No rounding is allowed.

The sum of the days' time, in minutes, per service will determine how many units are allowed to be billed. That number must not be exceeded. The total of minutes per service must be compared to the following grid, which determines the number of units allowed.

15 Minute Units	Timeframe
One (1) unit =	8-24 minutes
Two (2) units =	25-39 minutes
Three (3) units =	40-49 minutes
Four (4) units =	50-60 minutes

60 minute Units	Timeframe
One (1) unit =	50-60 minutes
Two (2) units =	110-120 minutes
Three (3) units =	170-180 minutes
Four (4) units =	230-240 minutes

Five (5) units =	290-300 minutes
Six (6) units =	350-360 minutes
Seven (7) units=	410-420 minutes
Eight (8) units=	470-480 minutes

30 Minute Units	Timeframe
One (1) unit =	25-49 minutes
Two (2) units =	50-60 minutes

In a single claim transaction, a provider may bill only for service time accumulated within a single day for a single beneficiary. There is no "carryover" of time from one day to another or from one beneficiary to another.

Documentation in the beneficiary's record must reflect exactly how the number of units is determined.

No more than four (4) units may be billed for a single hour per beneficiary or provider of the service.

NOTE: For services provided by a Qualified Behavioral Health Provider (QBHP), the accumulated time for the Adult Behavioral Health Services for Community Independence program service, per date of service, is one total, regardless of the number of QBHPs seeing the beneficiary on that day. For example, two (2) QBHPs see the same beneficiary on the same date of service and provides Adult Life Skills Development. The first QBHP spends a total of 10 minutes with the beneficiary. Later in the day, another QBHP provides Adult Life Skills Development to the same beneficiary and spends a total of 15 minutes. A total of 25 minutes of Behavioral Assistance was provided, which equals (two) 2 allowable units of service. Only one QBHP may be shown on the claim as the performing provider.

View or print the procedure codes for ABHSCI services.

253.001 Partial Hospitalization 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.	Mental health partial hospitalization treatment, less than 24 hours
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Partial Hospitalization is an intensive nonresidential, therapeutic treatment program. It can be used as an alternative to and/or a step-down service from inpatient residential treatment or to stabilize a deteriorating condition and avert hospitalization. The program provides clinical treatment services in a stable environment on a level equal to an inpatient program, but on a less than 24-hour basis. The environment at this level of treatment is highly structured and should maintain a staff-to-patient ratio of 1:5 to ensure necessary therapeutic services and professional	• Start and stop times of actual program participation by beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale for and treatment used that must coincide with the master treatment plan • Beneficiary's response to the treatment must include current progress or lack of progress toward symptom reduction and attainment of goals

monitoring, control, and protection. This service shall include at a minimum intake, individual therapy, group therapy, and psychoeducation. Partial Hospitalization shall be at a minimum (5) five hours per day, of which 90 minutes must be a documented service provided by a Mental Health Professional. If a beneficiary receives other services during the week but also receives Partial Hospitalization, the beneficiary must receive, at a minimum, 20 documented hours of services on no less than (4) four days in that week.	• Rationale for continued Partial Hospitalization Services, including necessary changes to diagnosis, master treatment plan or medication(s) and plans to transition to less restrictive services • All services provided must be clearly documented in the medical record • Staff signature/credentials	
NOTES	**UNIT**	**BENEFIT LIMITS**
Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual. The medical record must indicate the services provided during Partial Hospitalization.	Per Diem	DAILY MAXIMUM THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF DAYS THAT MAY BE BILLED (extension of benefits can be requested): 40
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider may not bill for any other services on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Partial Hospitalization must be provided in a facility that is certified by the Division of Behavioral Health Services as a Partial Hospitalization provider	11, 49, 52, 53	
EXAMPLE ACTIVITIES		
Care provided to a client who is not ill enough to need admission to facility but who has need of more intensive care in the therapeutic setting than can be provided in the community. This service shall include at a minimum intake, individual and group therapy, and psychosocial education. Partial hospitalization may include drug testing, medical care other than detoxification and other appropriate services depending on the needs of the individual.		

253.002 Adult Rehabilitative Day Service 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
QBHP Bachelors or RN QBHP Non-Degreed **View or print the procedure codes for ABHSCI services.**	Psychosocial rehabilitation services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
A continuum of care provided to recovering individuals living in the community based on	• Date of Service • Names and relationship to the beneficiary of

their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration. An array of face-to-face rehabilitative day activities providing a preplanned and structured group program for identified beneficiaries that aimed at long-term recovery and maximization of self-sufficiency, as distinguished from the symptom stabilization function of acute day treatment. These rehabilitative day activities are person- and family-centered, recovery-based, culturally competent, provide needed accommodation for any disability and must have measurable outcomes. These activities assist the beneficiary with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their chronic mental illness. The intent of these services is to restore the fullest possible integration of the beneficiary as an active and productive member of his/her family, social and work community and/or culture with the least amount of ongoing professional intervention. Skills addressed may include: emotional skills, such as coping with stress, anxiety or anger; behavioral skills, such as proper use of medications, appropriate social interactions and managing overt expression of symptoms like delusions or hallucinations; daily living and self-care skills, such as personal care and hygiene, money management and daily structure/use of time; cognitive skills, such as problem solving, understanding illness and symptoms and reframing; community integration skills and any similar skills required to implement a beneficiary's master treatment plan.	all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Staff to Client Ratio – 1:15 ratio maximum with the provision that client ratio must be reduced when necessary to accommodate significant issues related to acuity, developmental status and clinical needs.	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 6 units

		QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 90 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adult – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 13, 14, 22, 23, 31, 32, 33, 49, 50, 52, 53, 57, 71, 72, 99	

253.003 Supportive Employment 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.	Supportive Employment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Employment is designed to help beneficiaries acquire and keep meaningful jobs in a competitive job market. The service actively facilitates job acquisition by sending staff to accompany beneficiaries on interviews and providing ongoing support and/or on-the-job training once the beneficiary is employed. This service replaces traditional vocational approaches that provide intermediate work experiences (prevocational work units, transitional employment, or sheltered workshops), which tend to isolate beneficiaries from mainstream society. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.004 Supportive Housing 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for ABHSCI services.	Supportive Housing
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Supportive Housing is designed to ensure that beneficiaries have a choice of permanent, safe, and affordable housing. An emphasis is placed on the development and strengthening of natural supports in the community. This service assists beneficiaries in locating, selecting, and sustaining housing, including transitional housing and chemical free living; provides opportunities for involvement in community life; and facilitates the individual's recovery journey. Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention • Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented

	and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 Minutes	QUARTERLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 60
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider can bill up to 60 units per quarter (Quarters are defined as January-March, April-June, July-September, October-December) prior to an extension of benefits. A provider cannot bill any H2017 code on the same date of service.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.005 Adult Life Skills Development 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
QBHP Bachelors or RN QBHP Non-degreed **View or print the procedure codes for ABHSCI services.**	Comprehensive community support services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Life Skills Development services are designed to assist beneficiaries in acquiring the skills needed to support an independent lifestyle and promote an improved sense of self-worth. Life skills training is designed to assist in setting and achieving goals, learning independent living skills, demonstrate accountability, and making goal-directed decisions related to independent living (i.e., educational/vocational training, employment, resource and medication management, self-care, household maintenance, health, wellness and nutrition).	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter with beneficiary • Place of Service (If 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating intervention

Service settings may vary depending on individual need and level of community integration, and may include the beneficiary's home. Services delivered in the home are intended to foster independence in the community setting and may include training in menu planning, food preparation, housekeeping and laundry, money management, budgeting, following a medication regimen, and interacting with the criminal justice system.	• Document how interventions used address goals and objectives from the master treatment plan • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 Minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 8 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed • Registered Nurse	04, 11, 12, 16, 49, 53, 57, 99	

253.006 Peer Support 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ABHSCI services.	Self-help/peer services, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Peer Support is a consumer centered service provided by individuals (ages 18 and older) who self-identify as someone who has received or is receiving behavioral health services and thus is able to provide expertise not replicated by professional training. Peer providers are trained and certified peer specialists who self-identify as being in recovery from behavioral health issues. Peer support is a service to work with	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual contact • Place of Service (When 99 is used, specific location and rationale for location must be included)

beneficiaries to provide education, hope, healing, advocacy, self-responsibility, a meaningful role in life, and empowerment to reach fullest potential. Specialists will assist with navigation of multiple systems (housing, supportive employment, supplemental benefits, building/rebuilding natural supports, etc.) which impact beneficiaries' functional ability. Services are provided on an individual or group basis, and in either the beneficiary's home or community environment.	• Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 120
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Provider can only bill for 120 units (combined between H0038 and H0038, U8) per SFY	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Certified Peer Support Specialist • Certified Youth Support Specialist	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99	
EXAMPLE ACTIVITIES		
Peer support may include assisting their peers in articulating their goals for recovery, learning and practicing new skills, helping them monitor their progress, assisting them in their treatment, modeling effective coping techniques and self-help strategies based on the specialist's own recovery experience, and supporting them in advocating for themselves to obtain effective services.		

253.007 Treatment Plan 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for ABHSCI services.	Treatment Plan
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Treatment Plan is a plan developed in cooperation with the beneficiary (or parent or guardian if under 18) to deliver specific mental health services to restore, improve, or stabilize the beneficiary's mental health condition. The Plan must be based on individualized service	• Date of Service (date plan is developed) • Start and stop times for development of plan • Place of service • Diagnosis

needs as identified in the completed Mental Health Diagnosis, independent assessment, and independent care plan. The Plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The Plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, and time limitations for services. The plan must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and demonstrate cultural competence.	• Beneficiary's strengths and needs • Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs • Measurable objectives • Treatment modalities — The specific services that will be used to meet the measurable objectives • Projected schedule for service delivery, including amount, scope, and duration • Credentials of staff who will be providing the services • Discharge criteria • Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s) • Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/ date of signature • Physician's signature indicating medical necessity/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed when the beneficiary is determined to be eligible for services. Revisions to the Treatment Plan for Adult Behavioral Health Services for Community Independence must occur at least annually, in conjunction with the results from the Independent Assessment. Reimbursement for Treatment Plan revisions more frequently than once per year is not allowed unless there is a documented clinical change in circumstance of the beneficiary or if a beneficiary is re-assessed by the Independent Assessment vendor which results in a change of Tier. It is the responsibility of the primary mental health professional to insure that all individuals working with the client have a clear understanding and work toward the goals and objectives stated on the treatment plan.	30 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 4
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	Must be reviewed annually	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Rehabilitative	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 04, 11, 12, 14, 33, 49, 50, 53, 57, 71, 72

253.008 Aftercare Recovery Services 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
QBHP Bachelors or RN QBHP Non-Degreed **View or print the procedure codes for ABHSCI services.**	Psychosocial rehabilitation services, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
A continuum of care provided to recovering individuals living in the community based on their level of need. This service includes educating and assisting the individual with accessing supports and services needed. The service assists the recovering individual to direct their resources and support systems. Activities include training to assist the person to learn, retain, or improve specific job skills, and to successfully adapt and adjust to a particular work environment. This service includes training and assistance to live in and maintain a household of their choosing in the community. In addition, transitional services to assist individuals adjust after receiving a higher level of care. The goal of this service is to promote and maintain community integration.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Start and stop times of actual encounter • Place of Service (When 99 is used, specific location and rationale for location must be included) • Client diagnosis necessitating service • Document how treatment used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Any changes indicated for the master treatment plan which must be documented and communicated to the supervising MHP for consideration • Plan for next contact, if any • Staff signature/credentials/Date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
	15 minutes	YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 292
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above		

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face	2
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Qualified Behavioral Health Provider – Bachelors • Qualified Behavioral Health Provider – Non-Degreed	03, 04, 11, 12, 13, 14, 15, 16, 22, 23, 31, 32, 33, 34, 49, 50, 52, 53, 57, 71, 72, 99

254.001 Therapeutic Communities 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
Level 1 Level 2 **View or print the procedure codes for ABHSCI services.**	Behavioral health; long-term residential (nonmedical, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Therapeutic Communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability. Services address the broad range of needs identified by the person served. Therapeutic Communities employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The service emphasizes the integration of an individual within his or her community, and progress is measured within the context of that community's expectation.	• Date of Service • Names and relationship to the beneficiary of all persons involved • Place of Service • Document how interventions used address goals and objectives from the master treatment plan • Information gained from contact and how it relates to master treatment plan objectives • Impact of information received/given on the beneficiary's treatment • Staff signature/credentials/date of signature

NOTES	UNIT	BENEFIT LIMITS
Therapeutic Communities Level will be determined by the following: • Functionality based upon the Independent Assessment Score • Outpatient Treatment History and Response • Medication • Compliance with Medication/Treatment Eligibility for this service is determined by the Intensive Level Services standardized Independent Assessment.	Per Diem	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 180 185 **View or print the**

Prior to reimbursement for Therapeutic Communities in Intensive Level Services, a beneficiary must be eligible for Rehabilitative Level Services as determined by the standardized Independent Assessment. The beneficiary must then also be determined by an Intensive Level Services Independent Assessment to be eligible for Therapeutic Communities.		**procedure codes for ABHSCI services.**
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Adults – Ages 18 and Above	A provider cannot bill any other services on the same date of service.	
	PROGRAM SERVICE CATEGORY	
	Intensive	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Therapeutic Communities must be provided in a facility that is certified by the Division of Behavioral Health Services as a Therapeutic Communities provider	14, 21, 51, 55	

TOC not required

221.100 ARKids First-B Medical Care Benefits 2-1-22

Listed below are the covered services for the ARKids First-B program. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician (PCP) referral is required, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	$10 per visit
Audiological Services (only Tympanometry, CPT procedure code****, when the diagnosis is within the ICD range (**View ICD codes**.))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	$10 per visit
Chiropractor	Medical Necessity	PCP Referral	$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	$10 per visit
Durable Medical Equipment	Medical Necessity $500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	$10 per visit
Assessment	Medical Necessity	None	$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	$10 per visit
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30)	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Hospital, Inpatient	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	$10 per visit
Medical Supplies	Medical Necessity Benefit of $125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding $125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PCP Referral PA on treatment services	$10 per visit
School-Based Mental Health	Medical Necessity	PA Required (See Section 250.000 of the School-Based Mental Health provider manual.)	$10 per visit
Nurse Practitioner	Medical Necessity	PCP Referral	$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	$10 per visit
Podiatry	Medical Necessity	PCP Referral	$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to $5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of $5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to $5.00 per prescription.

****View or print the procedure codes for ARKids First-B procedures and services.

221.200 Exclusions 2-1-22

Services Not Covered for ARKids First-B Beneficiaries:

Adult Development Day Treatment (ADDT)

Audiological Services; EXCEPTION, Tympanometry, CPT procedure code*, when the diagnosis is within the ICD range. (View ICD codes.)

Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Diapers, Underpads, and Incontinence Supplies

Early Intervention Day Treatment (EIDT)

End Stage Renal Disease Services

Hearing Aids

Hospice

Hyperalimentation

Non-Emergency Transportation

Nursing Facilities

Orthotic Appliances and Prosthetic Devices

Personal Care

Private Duty Nursing Services

Rehabilitative Services for Children

Rehabilitative Services for Persons with Physical Disabilities (RSPD)

Targeted Case Management

Ventilator Services

***View or print the procedure codes for ARKids First-B procedures and services.**

222.300 Dental Services Benefit 2-1-22

Dental services benefits for ARKids First-B beneficiaries are one periodic dental exam, bite-wing x-rays, and prophylaxis/fluoride treatments every six (6) months plus one (1) day. Scalings are covered once per State Fiscal Year (SFY). Orthodontia services are also covered for ARKids First-B beneficiaries.

The **procedure codes listed in Section 262.150** may be billed for the periodic dental exams, interperiodic dental exams and prophylaxis/fluoride, and orthodontia services for ARKids First–B beneficiaries.

Refer to Section II of the Medicaid Dental Provider Manual for a complete listing of covered dental and orthodontia services. Procedures for dental treatment services that are not listed as a payable service in the Medicaid Dental Provider Manual may be requested on individual treatment plans for prior authorization review. These individually requested procedures and dental and orthodontia treatment services are subject to determination of medical necessity, review and approval by the Division of Medical Services dental consultants.

222.710 Introduction 2-1-22

The ARKids First-B Program supports preventive medicine for beneficiaries by reimbursing primary care physicians (PCPs) who provide medical preventive health screens and qualified screening providers to whom PCPs refer beneficiaries. ARKids First-B outreach efforts vigorously promote the program's emphasis on preventive medical health care. Beneficiary cost sharing does not apply to covered preventive medical health screens, including those for newborns.

The supplemental eligibility response request to an ARKids First-B beneficiary's identification card will indicate to the provider the date of the beneficiary's last preventive health screen

View or print the procedure codes for ARKids First-B procedures and services.

This information should be reviewed and verified, along with the beneficiary's eligibility, prior to performing a service. This information will assist the beneficiary's PCP or preventive health screen provider in determining the beneficiary's eligibility for the service and ensuring that

preventive health screens are performed in a timely manner in compliance with the periodicity chart for ARKids First-B beneficiaries.

Newborn screens do not require PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

Nurse practitioners, in addition to newborn preventive health screens, are authorized to provide other preventive health screens with a PCP referral. **Refer to Section 262.130** for preventive health screens procedure codes.

222.750 Health Education 2-1-22

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive, physical examination, and the visual, hearing or dental screening provide the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. **See Section 262.130** for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

A. Counseling Visits (two (2) per SFY).

View or print the procedure codes for ARKids First-B procedures and services.

* Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Referral of patient to an intensive tobacco cessation referral program.

C. These counseling sessions can be billed in addition to an office visit or EPSDT.

D. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Tobacco cessation sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**.

Refer to Section 257.000 and Section 292.900 of the Primary Care Physician manual for more information.

222.800 Schedule for Preventive Health Screens 2-1-22

The ARKids First – B periodic screening schedule follows the guidelines for the EPSDT screening schedule and is updated in accordance with the recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 18 years.

Age			
3 years	7 years	11 years	15 years
4 years	8 years	12 years	16 years
5 years	9 years	13 years	17 years
6 years	10 years	14 years	18 years

Medical screens for children are required to be performed by the beneficiary's PCP or receive a PCP referral to an authorized Medicaid screening provider. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. **See Section 262.130** for procedure codes.

224.000 Cost Sharing 2-1-22

Co-payment or coinsurance applies to all ARKids First-B services, with the exception of immunizations, preventive health screenings, family planning, prenatal care, eyeglasses, medical supplies and audiological services (only Tympanometry, CPT procedure code, when the diagnosis is within the ICD range (**View ICD codes**.)).

View or print the procedure codes for ARKids First-B procedures and services.

Co-payments or coinsurances range from up to $5.00 per prescription to 10% of the first day's hospital Medicaid per diem.

ARKids First-B families have an annual cumulative cost sharing maximum of 5% of their annual gross family income. The annual period is July 1 through June 30 SFY (state fiscal year). The ARKids First-B beneficiary's annual cumulative cost sharing maximum will be recalculated and the cumulative cost sharing counter reset to zero on July 1 each year.

The cost sharing provision will require providers to check and be alert to certain details about the ARKids First-B beneficiary's cost sharing obligation for this process to work smoothly. The following is a list of guidelines for providers:

1. On the day service is delivered to the ARKids First-B beneficiary, the provider must access the eligibility verification system to determine if the ARKids First-B beneficiary has current ARKids First-B coverage and whether or not the ARKids First-B beneficiary has met the family's cumulative cost sharing maximum.
2. The provider must check the remittance advice received with the claim submitted on the ARKids First-B beneficiary, which will contain an explanation stating that the ARKids First-B beneficiary has met their cost sharing cap.
3. It is strongly urged that providers submit their claims as quickly as possible to the Arkansas Medicaid fiscal agent for payment so that the amount of the ARKids First-B beneficiary's co-payment can be posted to their cost share file and the amount added to the accrual.

240.200 Prior Authorization (PA) Process for Interperiodic Preventive Dental Screens 2-1-22

Prior authorization for procedure code, Interperiodic Dental Screening Exam, must be requested on the ADA claim form or online with a brief narrative through the Prior Authorization Manipulation (PAM) software. **View or print the Department of Human Services Medicaid Dental Unit Address.** Refer to your Arkansas Medicaid Dental Services Provider Manual for detailed information on obtaining prior authorizations.

View or print the procedure codes for ARKids First-B procedures and services.

Refer to Section 222.300 of this manual for coverage and Section 262.150 billing information.

262.110 Medical Supplies Procedure Codes 2-1-22

The following medical supplies procedure codes may be billed by Medicaid-enrolled Home Health and Prosthetics providers for ARKids First-B beneficiaries.

View or print the procedure codes for ARKids First-B procedures and services.

NOTE: * must be prior authorized. Form DMS-679 must be used for the request for prior authorization. View or print form DMS-679 and instructions for completion.

**The costs are not subject to the $125 medical supplies monthly benefit limit.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

262.120 Durable Medical Equipment (DME) Procedure Codes 2-1-22

The following DME HCPCS procedure codes may be billed with appropriate modifiers by Medicaid-enrolled prosthetics providers for ARKids First-B beneficiaries.

View or print the procedure codes for ARKids First-B procedures and services.

NOTES: Codes denoted with an asterisk * must be prior authorized. Form DMS-679A must be used for the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

** Code must be prior authorized through the Division of Medical Services, Utilization Review. Form DMS-679 must be used for the request for prior authorization. **View or print form DMS-679 and instructions for completion.**

Codes denoted with ^ symbol are approved for special circumstance “Initial” billing (See Section 242.111 of the Prosthetics Medicaid Provider Manual for details regarding “initial” billing). These codes must be billed WITHOUT A MODIFIER to indicate the “Initial” bill circumstance applies – EXCEPTION – if a modifier KH is specifically indicated, that modifier must be used.

262.130 Preventive Health Screening Procedure Codes 2-1-22

There are two (2) types of full medical preventive health screening procedure codes to be used when billing for this service for ARKids First-B beneficiaries; Newborn and Child Preventive Health Screening:

1. ARKids First-B Preventive Health Screening: Newborn

   The initial ARKids First-B preventive health screen for newborns is similar to Routine Newborn Care in the Arkansas Medicaid Physician and Child Health Services (EPSDT) Programs.

   For routine newborn care following a vaginal delivery or C-section, procedure code, with the required modifier UA and a primary detail diagnosis (**View ICD codes**.) must be used

one time to cover all newborn care visits by the attending provider. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to code. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), and are considered to be the Initial Health Screening.

For newborn illness care, e.g., neonatal jaundice, following a vaginal delivery or C-section, use procedure codes range. Do not bill codes (routine newborn care) in addition to the newborn illness care codes.

2. ARKids First-B Preventive Health Screening: Children

Preventive health screenings in the ARKids First-B Program are similar to EPSDT screens in the Arkansas Medicaid Child Health Services (EPSDT) Program in content and application. Billing, however, differs from Child Health Services (EPSDT). All services, including the preventive health medical screenings, are billed in the CMS-1500 claim format for both electronic and paper claims.

All preventive health screenings after the newborn screen are to be billed using the preventive health screening procedure codes.

Providers may bill ARKids First-B for a sick child visit in addition to a preventive health screen procedure code for the same date of service if the screening schedule indicates a periodic screen is due to be performed.

View or print the procedure codes for ARKids First-B procedures and services.

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab
[3] Arkansas Medicaid description of the service

Immunizations and laboratory tests procedure codes are to be billed separately from comprehensive preventative health screens.

Billing for ARKids First-B services, including preventive health medical screenings and ARKids First-B SCHIP vaccine injection administration fees, are to be billed in the CMS-1500 claim format ONLY; for both electronic and paper claims.

262.150 Billing Procedure Codes for Periodic Dental Screens and Services and Orthodontia Services 2-1-22

View or print the procedure codes for ARKids First-B procedures and services.

A. Initial/Periodic Preventive Dental Screens

Periodicity schedule once each six months plus one day – must be billed with procedure code.

B. Interperiodic Preventive Dental Screens

ARKids First-B beneficiaries may receive interperiodic preventive dental screening, if required by medical necessity. There are no limits on these services; however, prior authorization must be obtained in order to receive reimbursement. Refer to Section 240.200 of this manual for dental prior authorization information.

Procedure code must be billed for an interperiodic preventive dental screen. **This service requires prior authorization (see Section 240.200)**.

The procedure codes listed in the table below must be billed for prophylaxis/fluoride.

Refer to Section 222.300 for further details regarding dental services for ARKids First–B beneficiaries.

C. Orthodontia Services

Comprehensive Orthodontic Treatment – Permanent Dentition

Other Orthodontic Devices

Refer to Section II of the Medicaid Dental Provider Manual for service definitions, information regarding reimbursement, prior authorization and other information pertaining to orthodontic treatment.

262.400 Billing Procedures for Preventive Health Screens 2-1-22

ARKids First-B reimburses providers for preventive health screenings performed at the intervals recommended by the American Academy of Pediatrics.

References in this section indicate that ARKids First-B preventive health screenings are similar to Arkansas Medicaid Child Health Services (EPSDT) screens in content and application.

View or print the procedure codes for ARKids First-B procedures and services.

However, please note this important distinction:

Claims for ARKids First-B preventive health screenings electronically or by paper must be billed in the CMS-1500 claim format.

NOTE: Certified nurse-midwives are restricted to performing the preventive health screen, Newborn, only, and must bill either code, with the required UA modifier, for initial newborn screen or codes for newborn illness care.

A Certified nurse-midwife may NOT bill procedure codes for child preventive health screens.

262.410 Primary Care Physician Referral Requirements for Preventive Health Screens 2-1-22

All preventive health screens for ARKids First-B beneficiaries must be provided by the primary care physician (PCP) of the beneficiary or by PCP referral to a qualified practitioner.

View or print the procedure codes for ARKids First-B procedures and services.

Newborn preventive health screens are exempt from the PCP referral requirement.

Immunizations for childhood diseases are exempt from the PCP referral requirement.

262.420 Limitation on Laboratory Procedures Performed During a Preventive Health Screen 2-1-22

ARKids First-B preventive health screens will not include laboratory procedures unless the screen is performed by the beneficiary's PCP, is conducted pursuant to a referral from the PCP or is included in the exceptions listed below.

View or print the procedure codes for ARKids First-B procedures and services.

Exceptions

The following tests are exempt from the above limitations and may continue to be billed in conjunction with a preventive health screen performed in accordance with existing Medicaid policy only if they are performed within seven (7) calendar days following the screen:

Claims for laboratory tests, other than those specified above, performed in conjunction with a preventive health screen will be denied unless the screen is performed by the PCP or pursuant to a referral from the PCP.

262.430 Vaccines for ARKids First-B Beneficiaries 2-1-22

ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information.**

Only a vaccine injection administration fee is reimbursed. When filing claims for administering vaccines for ARKids First-B beneficiaries, providers must use the CPT procedure code for the vaccine administered and the required modifier **SL only** for either electronic or paper claims. Providers must bill claims for ARKids First-B beneficiaries using the CMS-1500 claim format.

The following list contains the SCHIP vaccines available to ARKids-First-B beneficiaries through the Arkansas Department of Health.

View or print the procedure codes for ARKids First-B procedures and services.

262.431 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

   View or print the procedure codes for ARKids First-B procedures and services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

   1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
   2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
   3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
   4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

TOC not required

242.100 Procedure Codes 2-1-22

The procedure codes for billing chiropractic services are below. **View or print the procedure codes for Chiropractic services.**

*Procedure code is to be used when filing claims for chiropractic x-ray. This benefit is limited to two (2) per state fiscal year. This service counts against the $500 per beneficiary per state fiscal year laboratory and X-ray benefit limit.

242.310 Completion of the CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	

Field Name and Number		Instructions for Completion
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b.	RESERVED	Reserved for NUCC use.
	SEX	Not required.
c.	RESERVED	Reserved for NUCC use.
d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a.	INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
b.	OTHER CLAIM ID NUMBER	Not required.
c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.

Field Name and Number	Instructions for Completion
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Not required
17a. (blank)	Not required.
17b. NPI	
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.

Field Name and Number	Instructions for Completion
20. OUTSIDE LAB?	Not required
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail. **Refer to Section 242.100** for procedure codes.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider’s services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT’S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

213.710 Fetal Non-Stress Test 2-1-22

The fetal non-stress test is limited to two (2) medically necessary fetal non-stress test procedures per pregnancy. Providers must follow the benefit extension procedures in Section 214.000 to request that Medicaid authorize payment of a third or subsequent claim after two (2) claims have been paid in a nine-month period. The procedure code for a fetal non-stress test is in the link below.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

Post procedural visits are covered within the 10-day period following a fetal non-stress test.

272.412 Pudendal Nerve Block 2-1-22

CPT code may be billed when administering a pudendal nerve block.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.430 Family Planning Services for Beneficiaries 2-1-22

See Sections 215.200 through 215.260 for family planning coverage information.

Laboratory procedure codes covered for family planning are listed in **Section 272.431** of this manual.

For other billable family planning services, see Sections 272.440-272.533.

272.431 Family Planning Services Laboratory Procedure Codes 2-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.440 Billable Family Planning Services for Beneficiaries 2-1-22

A. Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail.** Laboratory procedure codes covered for family planning are listed in **Section 272.431**. Other billable family planning services are also listed in **Section 272.533**.

B. The following procedure code table explains the family planning visit services payable to certified nurse-midwives.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. The following procedure table explains family planning codes payable to certified nurse-midwives.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

* For Family Planning modifiers, FP and SB are required.

** See Section 272.533 H for additional billing information.

272.451 Specimen Collection 2-1-22

The policy in regard to collection, handling and/or conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization.

C. Specimen collection is not reimbursable when the provider collecting the specimen also performs laboratory tests on the specimen.

The following procedure codes may be used when billing for specimen collection:

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.452 Tobacco Cessation Counseling Services 2-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

* Exempt from PCP referral requirements.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18) and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**

272.470 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number midwife can refer interested individuals to the Department of Human Services through the The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician/certified nurse-midwife can refer interested individuals to the Department of Human Services through the Hospital/Physician/Certified Nurse-Midwife Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

For routine newborn care following a vaginal delivery or C-section, procedure code should be used one time to cover all newborn care visits. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s), and are considered to be the initial Child Health Services (EPSDT) screen. Routine newborn care is exempt from the PCP requirement.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

For illness care (e.g., neonatal jaundice), use procedure codes. Do **not** bill in addition to these codes.

For newborn resuscitation, use procedure code.

May be billed on the CMS-1500 claim form or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically for ARKids A beneficiaries. For ARKids B-beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center. **View or print the Provider Assistance Center contact information.**

For ARKids A (EPSDT) – Requires a CMS-1500 claim form; may be billed electronically or on paper.

For ARKids First B – Requires a CMS-1500 claim form; may be billed electronically or on paper.

See Sections 241.000 – 243.310 of the EPSDT manual for specific EPSDT billing instructions.

272.491 Method 1 – "Global" or "All-Inclusive" Rate 2-1-22

A. One charge for total obstetrical care is billed. The single charge would include the following:

1. Antepartum care, which includes:
   a. initial and subsequent history
   b. physical examinations
   c. recording of weight
   d. blood pressure
   e. fetal heart tones
   f. routine chemical urinalyses
   g. maternity counseling
   h. office visit charge when diagnosis is pregnancy related
2. Admission to the hospital. All admissions and subsequent hospital visits for the treatment of false labor.
3. Delivery - vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary.

4. Postpartum care, which includes hospital and office visits following vaginal delivery.

B. The global method must be used when the following conditions exist:

1. At least two months of antepartum care were provided culminating in delivery.
2. The patient was continuously Medicaid eligible for at least two months before delivery.

If either condition is not met, the claim will be denied. The denial will state either "monthly billing required" or "beneficiary ineligible for service dates."

C. When billing for global care, procedure code must be used.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

The provider should indicate in the date of service field of the claim form:

1. The first date of antepartum care after Medicaid eligibility has been established
2. The date of delivery
3. If these two dates are not entered and are not at least two months apart, payment will be denied. The filing deadline will be calculated based on the date of delivery.

D. No benefits are counted against the beneficiary's annual office visit benefit limit if the global method is used.

E. The global method of billing should be used when one or more certified nurse-midwives in a group sees the patient for one or more prenatal visits. The certified nurse-midwife who delivers the baby should be listed as the attending provider on the claim for global obstetric care.

272.492 Method 2 – "Itemized Billing" 2-1-22

Itemized billing must be used when the following conditions exist:

A. Less than two months of antepartum care was provided.

B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.

C. If Method 2 is used to bill OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

D. If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure code should be billed for vaginal delivery. Procedure codes may not be billed in addition to procedure code. These procedures will be reviewed on a post-payment basis to ensure that they are not billed in addition to antepartum or postpartum care.

E. Providers may bill laboratory and X-ray services separately using the appropriate CPT procedure codes if this is the certified nurse-midwife's standard office practice.

1. When lab tests and/or x-rays are pregnancy related, the referring certified nurse-midwife must be sure to code appropriately when these services are sent to the lab or x-ray facility. The diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.
2. The obstetrical laboratory profile procedure code consists of four components: complete blood count, VDRL, Rubella and blood typing with RH. If the ASO titer is performed, the test should be billed separately using the individual code.

3. As with any laboratory procedure, if the specimen is sent to an outside laboratory, only a collection fee may be billed. The laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 272.450 of this manual.

NOTE: Payment will not be made for emergency room certified nurse-midwife charges for an OB patient admitted directly from the emergency room into the hospital for delivery.

272.493 Obstetrical Care Without Delivery 2-1-22

Certified nurse-midwives must use procedure code with modifier **UA** to bill for one to three visits for antepartum care without delivery.

Procedure code with no modifier must be used by providers to bill four to six visits for antepartum care without delivery. Procedure code with no modifier is to be used for 7 or more visits without delivery.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

This enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided. Coverage for this service will include routine sugar and protein analysis. One unit equals one visit. Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the claim and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by the Arkansas Medicaid fiscal agent prior to 12 months from 1-10-05 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

272.494 Fetal Non-Stress Test, Fetal Echography (Ultrasound) and External Fetal Monitoring 2-1-22

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. The fetal non-stress test, procedure code, has a benefit limitation of two (2) per pregnancy. Prior authorization is not required.

B. CPT procedure code is applicable only to internal fetal monitoring during labor by a consultant. Procedure code with modifier **U1**, for external fetal monitoring, is payable to the certified nurse-midwife when performed in a certified nurse-midwife's office or clinic. Certified nurse-midwives may bill no more than one unit per day of external fetal monitoring, not to exceed two (2) per pregnancy.

C. Benefit limits apply to fetal echography (ultrasound), procedure codes.

D. Fetal echography is limited to two (2) per pregnancy. If it is necessary to exceed these limits, the certified nurse-midwife must request an extension of benefits. See Section 214.000 for benefit extension procedures.

272.495 Risk Management Services for Pregnancy 2-1-22

A certified nurse-midwife may provide the risk management services listed below if he or she employs the professional staff indicated in the service descriptions below. If a certified nurse-midwife does not choose to provide the risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy. Each of the risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

A. Risk Assessment

A medical, nutritional and psychosocial assessment by the certified nurse-midwife or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
2. Nutritional assessment to include:
   a. 24-hour diet recall
   b. Screening for anemia
   c. Weight history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

B. Case Management Services

Services by a certified nurse-midwife, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services. (Examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to perform delivery following-up to verify that the patient kept appointment, rescheduling appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management service contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (Certified Nurse-Midwife, Public Health Nurse, Nutritionist or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan or
2. Nutritional care plan follow-up and reassessment, as indicated.

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan or
2. Social work plan follow-up, appropriate intervention and referrals.

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be made by certified nurse-midwife order (includes hospital discharge order).

A certified nurse-midwife may order a home visit for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Procedure codes: CPT procedure codes as applicable.

272.502 Non-Emergency Services 2-1-22

Procedure code (modifier **U3**) should be billed for a non-emergency certified nurse-midwife visit.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

272.533 Injections, Therapeutic and/or Diagnostic Agents 2-1-22

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

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

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

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

Cannot be billed when the drug administered is not FDA approved.

See the table below when billing:

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

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 272.531 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the certified nurse-midwife if performed in any other setting. Therapeutic injections should only be provided by certified nurse-midwives experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

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

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

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

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.**

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

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

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

D. **Vaccines for Children (VFC)**

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

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the VFC Program; however vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids First-B SCHIP vaccines. **View or print the Department of Health contact information.**

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables in this section of this manual. See Part F of this section.

E. Billing of Multi-Use and Single-Use Vials

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

1. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.
2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
    a. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
    b. **Multi-Use Vials** are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
    c. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
    d. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing.

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

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

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

F. Tables of Payable Procedure Codes

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

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

2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years(y) or months (m).
4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 240.000 for prior authorization.)

G. **Process for Obtaining a Prior Authorization (PA) Number from Arkansas Foundation for Medical Care (AFMC)**

In collaboration with AFMC, DMS is changing the process for acquiring prior approval for drug procedure codes from a prior approval letter to a PA number. Instead of attaching a prior approval letter to a paper claim, providers will now list the PA number on the claim. This will mean that effective for claims submitted on and after August 26, 2016, drug procedure codes requiring PA should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim. Additionally, these procedure codes requiring a PA will no longer require manual review during the processing of the claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the time of the effective date of this policy. The letter will contain a PA number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding PA numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A PA must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a PA is required in a provider manual or an official Division of Medical Services correspondence.

The PA requests should be completed using the approved AFMC PA request form and must be submitted by mail, fax or https://afmc.org.reviewpoint/ **(View or print PA form.)**

A decision letter will be returned to the provider by fax or *e-mail* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary.

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

H. **Contact Information for Obtaining Prior Authorization**

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

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	**https://afmc.org.reviewpoint/**
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

I. All family planning procedures require an FP modifier and a primary family planning diagnosis on the claim.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 272.531 for NDC protocol.)

See Section 240.000-240.200 for prior authorization procedures.

List 003/103 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 003/103 restrictions apply to ages twenty-one (21) years and above unless otherwise indicated in the age restriction column.

TOC not required

262.100 Children's Services Targeted Case Management Procedure Code 2-1-22

Providers of Children's Services targeted case management (TCM) must bill for services provided using the procedure code and modifiers shown in the table below. Providers must use this procedure code and the indicated modifiers when billing either electronically or on paper for Children's Services TCM services.

View or print the procedure codes for Children's Services Targeted Case Management (TCM) services.

TOC not required

212.000 Summary of Coverage 2-1-22

The Dental Program covers an array of common dental procedures for individuals of all ages. However, there are specific limitations for coverage for individuals age 21 and over.

Effective for dates of service on and after July 1, 2009, dental procedures will be covered for Medicaid eligible beneficiaries age 21 and over. However, there is a benefit limit for covered services of $500.00 per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Extractions and complete and partial dentures are excluded from the $500.00 benefit limit for adults.

Medicaid dental procedure codes are listed in **Section 262.100** for beneficiaries under age 21. Procedure codes for individuals age 21 and over are listed in **Section 262.200**. Each section lists the procedure codes covered, prior authorization requirements and the necessity of submitting X-rays with the treatment plan. **Section 262.200** also lists the procedure codes that are benefit limited.

214.100 Tobacco Cessation Products and Counseling Services 2-1-22

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

Counseling services and benefits are defined below:

A. Prescribers must review the Public Health Service (PHS) guideline-based checklist with the patient.

B. The prescriber must retain the counseling checklist and file in the patient records for auditing. **View or print the checklist**.

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. For beneficiaries age twenty-one (21) and over, counseling procedures will count against the $500 adult dental benefit limit. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under that minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. Beneficiaries who are pregnant are allowed up to four (4) 93-day courses of treatment per calendar year.

NOTE: The course of treatment is defined as three consecutive months.

F. If the beneficiary is in need of intensive tobacco cessation services, the provider may refer the beneficiary to an intensive tobacco cessation program: **View or print the Arkansas Be Well Referral Form.**

G. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

H. Tobacco counseling for the control and prevention of oral disease must be billed when the provider counsels and refers the beneficiary to an intensive tobacco cessation program.

I. Behavior management by report must be billed when tobacco counseling for the control and prevention of oral disease has been provided to the beneficiary.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

J. Refer to **Section 262.100** and **262.200** for procedure codes and billing instructions.

215.000 Child Health Services (EPSDT) Dental Screening 2-1-22

The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Services (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) periodic dental screening exam is limited to two screening exams every six (6) months plus one (1) day for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See **Section 262.100** to view the procedure code for periodic dental screening exams.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening exam twice per SFY. Extension of benefits is available in cases of medical necessity. **View or print form ADA-J430.** See **Section 262.100** for the interperiodic dental screening exam procedure code.

NOTE: ARKids First-B beneficiaries may also receive an interperiodic dental screening exam twice per SFY. There is no extension of benefits for ARKids First-B beneficiaries.

Extension of benefits requests, in addition to a narrative and any supporting documentation, should be submitted to the Division of Medical Services Dental Care Unit – ATTN Dental Extension of Benefits. **View or print the Division of Medical Services Dental Care Unit contact information**.

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

216.200 Bitewing Radiographs 2-1-22

Bitewing radiographs are covered for beneficiaries of all ages. There are different limitations of coverage for beneficiaries under age 21 and for those beneficiaries age 21 and older.

The EPSDT periodic screening exam may include only two bitewings and is allowed every six (6) months plus one (1) day for beneficiaries under age 21. See **Section 262.100** for the appropriate procedure code.

Two bitewing films are allowed once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. See **Section 262.200** for appropriate procedure codes.

216.300 Intraoral Film 2-1-22

When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code must be used for the first film and procedure code for each additional single film.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the beneficiary identification number and stapled to the back of the claim form, as noted in Section 216.000.

217.100 Dental Prophylaxis and Fluoride Treatment 2-1-22

Dental prophylaxis and a fluoride treatment are preventive treatments covered by Medicaid. Prophylaxis, in addition to application of topical fluoride and/or fluoride varnish, is covered every six (6) months plus one (1) day for beneficiaries under age 21. Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Physicians and nurse practitioners must complete training on dental caries risk and have an approved fluoride varnish certification from the Arkansas Department of Health, Office of Oral Health. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate to Provider Enrollment. The course that meets the requirements outlined by the ACT can be accessed at **http://ar.train.org**. If further treatment is needed due to severe periodontal problems, the provider must request prior authorization with a brief narrative.

Prophylaxis and fluoride treatments are each covered once per state fiscal year (July 1 through June 30) for beneficiaries age 21 and over. Topical fluoride treatment or fluoride varnish is covered every six (6) months plus one (1) day for beneficiaries under age 21.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

Medicaid does not reimburse for nitrous oxide for examinations, fluorides, oral prophylaxis and sealants unless other procedures are performed at the same time.

A provider may generally perform the following procedures without prior authorization:

A. Periodic EPSDT screening exam (for beneficiaries under age 21).

B. Prophylaxis, topical fluoride and/or fluoride varnish.

C. Periapical X-rays, amalgam-composite restorations (except four or more surfaces).

D. Pulpotomies for deciduous teeth. (Pulpotomies are not a covered service for beneficiaries age 21 and over.)

E. Chrome crowns on deciduous teeth.

See Sections **262.100** and **262.200** for applicable codes.

218.000 Space Maintainers 2-1-22

Space maintainers are covered for beneficiaries under age 21 and require prior authorization. X-rays must be submitted with the request for prior authorization. When submitting a treatment plan or claim for space maintainers, identify the missing tooth in the tooth column on the ADA claim form and submit the X-ray to show the tooth for which the space is maintained. See **Section 262.100** for applicable procedure codes.

Space maintainers are not covered for beneficiaries age 21 and over.

219.100 Amalgam Restorations 2-1-22

Amalgam restorations are to be used on all teeth distal to the cuspids for beneficiaries of all ages. When submitting a claim for amalgam restorations, the tooth (teeth) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. Amalgam restorations do not require prior authorization. If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate. See Sections **262.100** and **262.200** for applicable procedure codes.

219.200 Composite Resin Restorations 2-1-22

Composite-resin restorations may be performed for anterior teeth for beneficiaries of all ages. Four or more surface composite-resin restorations require prior authorization. When submitting a claim for composite restorations, the tooth number(s) and all surfaces to be restored must be indicated on the same line with appropriate code and provider fee. **If a provider chooses to do posterior composites, reimbursement will be given at the amalgam reimbursement rate**. See Sections **262.100** and **262.200** for applicable procedure codes.

Only one amalgam or composite restoration per surface is allowed every 2 years.

220.000 Crowns – Single Restorations Only 2-1-22

Crowns are covered for individuals of all ages.

A. Chrome (Stainless Steel) Crowns - The Medicaid Program will cover chrome (stainless steel) crowns on deciduous posterior teeth only as an alternative to two or three surface alloys. Medicaid will cover chrome crowns on permanent posterior teeth only for loss of cuspal function. Stainless steel crowns on deciduous teeth do not require prior authorization. Prior authorization is required for crowns on all permanent teeth.

B. Anterior Crowns - Prefabricated stainless steel or prefabricated resin crowns may be approved for anterior teeth for beneficiaries under age 14. Prior authorization is required, and X-rays must be submitted to substantiate need.

C. Cast Crowns - Medicaid does not cover cast crowns for posterior teeth.

D. Porcelain-to-Metal Crowns - Porcelain-to-metal crowns may be approved only in unusual cases for anterior incisors and cuspids for beneficiaries under age 21. These cases must be submitted for prior authorization (PA) with complete treatment plans for all teeth and complete series X-rays or panoramic film with bitewings. Photographs are helpful, but are not required.

E. Post and Core in Addition to Crown - Medicaid does not cover core buildups or post and core buildups. This includes an amalgam filling with a stainless steel crown. An exception to this rule may be anterior fractures due to recent trauma in cases that do not involve other extractions, missing teeth or rampant caries in the same arch.

Fillings are not allowed on tooth numbers with crowns within one year of the crown.

See Sections **262.100** and **262.200** for applicable procedure codes.

221.000 Endodontia 2-1-22

Pulpotomy for deciduous teeth may be performed without prior authorization for beneficiaries under age 21. **Pulpotomies are not covered for individuals age 21 and over.**

Current indications require carious exposure of the pulp. Payment for pulp caps is included in the fee for restorations and is not payable separately.

Endodontic therapy is not covered for individuals age 21 and over.

To be reimbursed, the completed endo-fill should conform to current standards, that is, complete obturation of all canals to within 1mm to 2mm of radiographic apex.

The fee for endodontic therapy does not include restoration to close a root canal access, but does include films for measurement control and post-op.

Medicaid does not cover endodontic retreatment, apexification, retrograde fillings or root amputation. **See Section 262.100** for applicable procedure codes.

222.000 Periodontal Procedures 2-1-22

Periodontal treatment is available for beneficiaries of all ages. When periodontal treatment is requested, a brief narrative of the patient's condition, photograph(s) and X-rays are required. Each quadrant to be treated must be indicated on separate lines when requesting prior authorization or payment. Prior authorization will require a report, a periochart, and a complete series of radiographs that reflects evidence of bone loss, numerous 4-5 mm pockets and obvious calculus. See Sections **262.100** and **262.200** for applicable procedure codes.

223.000 Removable Prosthetic Services (Full and Partial Dentures, Including Repairs 2-1-22

A. Benefits

Full and acrylic partial dentures are covered for beneficiaries of all ages. Full dentures or acrylic partial dentures may be approved for use instead of fixed bridges.

Beneficiaries age 21 and over are allowed only one complete maxillary denture and one complete mandibular denture per lifetime.

Beneficiaries age 21 and over are allowed only one upper and one lower partial per lifetime.

Repairs of dentures and partials are covered but are benefit-limited for beneficiaries age 21 and over. See Sections **262.100** and **262.200** for applicable procedure codes.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

B. Prior Authorization Requirements

Prior authorization is required for dentures (full or partial) for beneficiaries under the age of 21.

Prior authorization is required for partial dentures for beneficiaries age 21 and over.

Prior authorization is not required for full dentures for beneficiaries age 21 and over.

For dentures that require prior authorization, a complete series of X-rays and a complete treatment plan, including tooth numbers to be replaced by partial dentures, must be submitted with prior authorization requests. See Sections **262.100** and **262.200** for further information regarding prior authorization for dentures.

Prior authorization is required for repairs of dentures and partials for eligible beneficiaries of all ages. A history and date of original insertion must be submitted with the prior authorization request. See Sections **262.100** and **262.200** for applicable procedure codes.

C. Required Process for Submitting Adult Dentures and Partials to Dental Lab

For eligible Medicaid beneficiaries age 21 and over, all dentures, whether full or partial, must be manufactured by the Medicaid-contracted dental lab. **View or print contact information for Medicaid Dental Contractor.**

When Medicaid issues a prior authorization for partial dentures for a beneficiary age 21 and over, the Dental Lab Request Form with the prior authorization number is returned to the dental provider's office. When the dental provider receives the prior authorization, the authorization will be for a maximum of six (6) (three upper and three lower) limited oral evaluations/problem-focused visits along with authorization for the diagnostic casts. The dental provider must then send the Medicaid-contracted dental lab the completed Dental Lab Request Form with the prior authorization number and models to make the adult partial dentures. **If the dental lab does not receive the Dental Lab Request Form, the lab will make the partial dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** **View or print contact information for Medicaid Dental Contractor.**

Though prior authorization is not required for full dentures for beneficiaries age 21 and over, the dental provider must send the Dental Lab Request Form and models directly to the Medicaid-contracted dental lab. The Dental Lab Request Form must clearly indicate that the beneficiary is a Medicaid beneficiary and the dentures are being requested pursuant to the Medicaid benefit plan. **If the dental lab does not receive the request form, the lab will make the full dentures and bill directly to the dental provider's account, and there will be no payment by Medicaid.** The dental provider will be reimbursed for a maximum of six (6) (three upper and three lower) limited oral evaluations/problem-focused visits and two (2) (one upper and one lower) diagnostic casts. **View or print contact information for Medicaid Dental Contractor.**

D. Patient Consent

Dental offices that render a patient edentulous must also fabricate dentures for the patient. If the patient has indicated that he or she is willing to pay out of pocket to have the dentures fabricated by the dental office and not through the contracted Medicaid Dental Lab, then the dental office must secure the patient's written consent on a form to be designed by the dental office and maintained in the patient's record. Beneficiaries who purchase dentures outside of the Medicaid dental program remain eligible for the Medicaid once-in-a-lifetime denture benefit.

225.100 Simple Extraction 2-1-22

Simple extractions may be performed without prior approval. Simple extractions of 3rd molars do not require prior authorization.

When a simple extraction evolves into a surgical extraction, providers must write a brief explanation of the circumstances if the problem is not indicated on the X-ray. Normally, surgical extractions imply sectioning, suturing and bone removal or any combination of these procedures. Providers must submit the claim, with the X-ray, for authorization and payment to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**. See Sections **262.100** and **262.200** for applicable procedure codes.

225.200 Surgical Extractions 2-1-22

Surgical extractions for beneficiaries of all ages require prior authorization and X-rays to substantiate need. The dental consultant may require a second opinion when reviewing treatment plans for extractions.

Surgical extractions performed on an emergency basis (See Section 234.000) for relief of pain may be reimbursed subject to the approval of a Medicaid dental consultant. In these cases, the claim with X-ray and a brief explanation should be submitted to the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information**.

For beneficiaries under the age of 21, the fee for surgical extraction includes local anesthesia and routine post-operative care. See Sections **262.100** and **262.200** for applicable procedure codes. Anesthesia is not a covered service for beneficiaries 21 and over.

225.300 Traumatic Accident 2-1-22

In cases of traumatic accident and when time is of prime importance, the dental provider may perform the necessary procedure(s) immediately. The procedure code chart found in Sections **262.100** and **262.200** identifies the procedures that may be billed "By Report" and those which must be prior authorized before reimbursement may be made. The chart also indicates the procedures that require submission of X-rays. Pre- and post-operative X-rays, if requested, must be made available to the Division of Medical Services.

225.500 Deep Sedation and General Anesthesia 2-1-22

Providers administering general anesthesia services must possess the appropriate permit as required by Arkansas law. Services performed in the dental office must be documented in the patient's record to include specific information on intubation, pharmacologic agents and amounts used, monitoring of vital signs and total anesthesia time. Prior authorization is required for deep sedation and general anesthesia procedures. General anesthesia and intravenous sedation will not be reimbursed for periods of time in excess of two (2) hours. Are not allowed on the same day.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

These codes are subject to post payment review; therefore, providers should be prepared to justify utilization of these procedures and the amount of time patients were kept under deep sedation and general anesthesia.

227.000 Professional Visits 2-1-22

Professional visits are payable if prior authorized. Because it is not always possible to plan these calls, the provider should submit a claim with a concise explanation of the circumstances. These visits are subject to review by the dental consultant.

When a treatment is necessary and no procedure code is applicable, a written explanation of the treatment and the usual and customary fee charged to a private patient must be submitted to the Medicaid Program. The dental consultant will stipulate an exact fee to be paid if the treatment is authorized. See Sections **262.100** and **262.200** for applicable procedure codes.

262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21 2-1-22

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

NOTE: Only physicians who have completed the training on dental caries and have an approved fluoride varnish certification on file with Provider Enrollment can bill for the fluoride varnish treatment. Eligible physicians may delegate the application to a nurse or other licensed healthcare professional under his or her supervision that has also completed the online training. Providers must check the Supplemental Eligibility Screen to verify that topical fluoride treatment or fluoride varnish was not applied by another Medicaid dental provider.

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

* Revenue code

**(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

** Prior authorization is required for panoramic X-rays performed on children under six years of age (See Section 216.100).

Child Health Services (EPSDT) Dental Screening (See Section 215.000)
Radiographs (See Sections 216.000 – 216.300)
Tests and Laboratory
Preventive
Dental Prophylaxis (See Section 217.100)
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)
Dental Sealants (See Section 217.200)
Space Maintainers (See Section 218.000)
Restorations (See Sections 219.000 – 219.200)
Amalgam Restorations (including polishing) (See Section 219.100)
Composite Resin Restorations (See Section 219.200)
Crowns – Single Restoration Only (See Section 220.000)
Endodontia (See Section 221.000)
Pulpotomy
Endodontic (Root Canal) therapy (including treatment plan, clinical procedures and follow-up care)
Periapical Services
Periodontal Procedures (See Section 222.000)
Surgical Services (including usual postoperative services)
Complete dentures (Removable Prosthetics Services) (See Section 223.000)
Partial Dentures (Removable Prosthetic Services) (See Section 223.000)
Repairs to Partial Denture (See Section 223.000)
Fixed Prosthodontic Services (See Section 224.000)
Oral Surgery (See Section 225.000)
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)
Other Surgical Procedures
Osteoplasty for Prognathism, Micrognathism or Apertognathism
Frenulectomy
Orthodontics (See Section 226.000)
Minor Treatment of Control Harmful Habits
Comprehensive Orthodontic Treatment – Permanent Dentition
Other Orthodontic Devices
Anesthesia
Consultations (See Section 214.000)
Smoking Cessation

Unclassified Treatment

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older 2-1-22

The following list shows the procedure code, procedure code description, whether or not prior authorization is required, whether an X-ray should be submitted with a treatment plan and if there is a benefit limit on a procedure.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

The column titled **Benefit Limit** indicates the benefit limit, if any, and how the limit is to be applied. When the column indicates **"Yes, $500.00",** then that item, when used in combination with other items listed, cannot exceed the $500.00 Medicaid maximum allowable reimbursement limit for the state fiscal year (July 1 through June 30). **Other limitations** are also shown in the column (i.e.: **1 per lifetime**). If **"No"** is shown, the item is not benefit limited.

NOTE: The use of the symbol, ⁂, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Dental Screening (See Section 215.000)
Radiographs (See Sections 216.000 – 216.300)
Tests and Laboratory
Dental Prophylaxis (See Section 217.100)
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)
Restorations (See Sections 219.000 – 219.200)
Amalgam Restorations (including polishing) (See Section 219.100)
Composite Resin Restorations (See Section 219.200)
Crowns – Single Restoration Only (See Section 220.000)
Surgical Services (including usual postoperative services)
Repairs to Complete and Partial Dentures (See Section 223.000)
Fixed Prosthodontic Services (See Section 224.000)
Oral Surgery (See Section 225.000)
Simple Extractions (includes local anesthesia and routine postoperative care) (See Section 225.100)
Surgical Extractions (includes local anesthesia and routine postoperative care) (See Section 225.200)
Other Surgical Procedures
Osteoplasty for Prognathism, Micrognathism or Apertognathism
Unclassified Treatment
Smoking Cessation

262.400 Billing Instructions – ADA Claim Form - Paper Claims Only 2-1-22

Dental providers must complete the ADA claim form when:

A. Billing for services when using the ADA procedure codes

B. Requesting prior authorization

C. Approving prior authorization

D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information.**

Completed claim forms should be forwarded to the Claims Department. **View or print the Claims Department contact information.**

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/ Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.

Field Number and Name	Instructions for Completion
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the patient Medicaid ID number.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.

Field Number and Name	Instructions for Completion
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
29. Procedure Code	Required for Medicaid. These codes are listed in **Section 262.100** for beneficiaries under age 21 or **Section 262.200** for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	

Field Number and Name	Instructions for Completion
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility The full list is available online at **http://www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf**.
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Required.
50. License Number	Optional.
51. SSN or TIN	Optional.

Field Number and Name	Instructions for Completion
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. **View or print form ADA-J430**.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.

262.500 Special Billing Procedures for ADA Claim Form 2-1-22

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

A. Each procedure must be shown on a separate line, such as:

1. Extractions
2. Upper partials

3. Lower partials
4. Upper denture relines
5. Lower denture relines

B. When a complete intraoral series is made for beneficiaries under age 21, the dentist must use procedure code rather than indicating each intraoral film on a separate line.

C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code must be used for the first film and procedure code for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the beneficiary identification number and stapled to the back of the claim form.

D. Post-operative X-rays must accompany all claims with root canals for beneficiaries under age 21. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

E. Prophylaxis and fluoride must be indicated on the same line of the form using code. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.

F. Indicate the tooth number when submitting claims for code, intraoral single film. When a complete series is made for beneficiaries under age 21, providers must use code rather than indicating each tooth on a separate line.

G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.

H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.

I. Use procedure code for prophylaxis-adult, ages 10 through 99, and procedure code for prophylaxis-child, ages 0 through 9.

263.100 CPT Procedure Codes 2-1-22

The provider should carefully read and adhere to the following instructions so that claims may be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

A. If these procedures are the result of a Child Health Services (EPSDT) screen/referral, enter "E" in Field 24H.

B. These procedures are restricted to the following places of service: inpatient hospital, outpatient hospital, doctor's office, patient's home, nursing home and skilled nursing facility.

C. Radiology procedures are payable only in the dentist's office. The place of service (POS) codes may be found in Section 262.300 of this manual. **These services require a PCP referral**.

The claim form CMS-1500 must be used by dentists billing the Medicaid Program for these medical procedures. Each service must be billed on a separate form. See Section 263.300 for complete billing instructions.

A. When billing for extractions, a listing of teeth extracted by date, tooth number and ADA code number must be attached.

B. Beneficiaries in the Child Health Services (EPSDT) Program are not benefit limited.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

See the Arkansas Medicaid Dental Fee Schedule for covered procedure codes.

263.110 CPT Procedure Codes that Require Prior Authorization Before Performing the Procedure 2-1-22

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.310 Completion of CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.

Field Name and Number			Instructions for Completion
7.	INSURED'S ADDRESS (No., Street)		Required if insured's address is different from the patient's address.
	CITY		
	STATE		
	ZIP CODE		
	TELEPHONE (Include Area Code)		
8.	RESERVED		Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)		If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	RESERVED	Reserved for NUCC use.
		SEX	Not required.
	c.	RESERVED	Reserved for NUCC use.
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:		
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER		Not required when Medicaid is the only payer.
	a.	INSURED'S DATE OF BIRTH	Not required.
		SEX	Not required.
	b.	OTHER CLAIM ID NUMBER	Not required.

Field Name and Number	Instructions for Completion
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is not required for Children's Services TCM. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.300 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from **Section 262.100** or **Section 262.200**.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do **not** include in this total the automatically deducted Medicaid ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number		Instructions for Completion
32.	SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a.	(blank)	Not required.
b.	(blank)	Not required.
33.	BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
	a. (blank)	Enter NPI of the billing provider or
	b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

263.400 Special Billing Procedure for the CMS-1500 Claim Form 2-1-22

CPT-4 procedure codes must be billed on the CMS-1500 claim form by dentists enrolled in the Medicaid Program when the procedure is provided to an eligible Medicaid beneficiary and is medically necessary. **View a CMS-1500 sample form.** These procedure codes and their descriptions are located in the *American Medical Association Current Procedural Terminology (CPT)*. Refer to Section III for information on how to purchase a copy of this publication.

NOTE: Procedure code (Hospital Discharge Day Management) is payable for medical services. Procedure code may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

NOTE: Covered CPT-4 procedure codes listed in this section are covered by Medicaid for eligible beneficiaries of all ages. The Arkansas Medicaid ADA Procedure Codes are covered only for eligible beneficiaries under the age of 21 years participating in the Child Health Services (EPSDT) Program.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.410 Multiple Quadrants Billing Instructions 2-1-22

When billing for multiple applications of any of the following procedures on the same date of service in varying quadrants of a patient's mouth, indicate the number of quadrants (1, 2, 3, 4) in Field 24G:

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.420 Anesthesia Services 2-1-22

Anesthesia services are billed using the CMS-1500 claim format.

A. The Arkansas Medicaid Program covers the anesthesia procedure codes (code range 00100 through 01999) listed in the Current Procedural Terminology (CPT-4) code book.

B. Providers must bill anesthesia time.

C. Providers must use anesthesia modifiers P1 through P5 as listed in the CPT manual.

D. Providers may bill electronically unless paper attachments are required.

E. When providers bill on paper, any applicable modifier(s) are also required.

The procedure code and the time involved must be entered in Field 24D. The number of units (each 15 minutes, or portion thereof, of anesthesia equals 1 time unit) must be entered in Field 24G.

The procedure code listed under the "Qualifying Circumstances" in the Anesthesia Guidelines in the CPT requires medical care services. When surgical field avoidance is a qualifying factor of the anesthesia service, the provider must bill, in addition to the basic anesthesia procedure code, modifier 22, and must bill "1" unit of service.

Procedure code may be billed by oral surgeons for anesthesia for inpatient or outpatient dental surgery using place of service code 24, 21, 22, or 11, as appropriate. The code does not require prior approval for anesthesia claims.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

263.421 Anesthesia Procedure Codes 2-1-22

Oral surgeons must use the following anesthesia procedure codes when billing on paper.

View or print the Dental services procedure codes for covered beneficiaries.

For dental services provided by dental managed care providers, please see the respective provider's manual.

TOC not required

214.300 Foster Care Intake Physical Examination in the EPSDT Program 2-1-22

Arkansas Medicaid beneficiaries entering the Arkansas foster care system are required to receive an intake physical examination within the first seventy two (72) hours. If the EPSDT provider who performs the screening is not the beneficiary's PCP, the intake physical examination should be billed with procedure codes and modifiers **EP** and **H9**.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Billing with these procedure codes and modifiers will allow the claim to be submitted for payment without a referral from the beneficiary's PCP and will alert the system not to count the screen toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

If the EPSDT provider who performs the screen is the beneficiary's PCP, the intake physical exam should be billed with procedure codes and modifiers **EP** and **H9**. Billing with these procedure codes and modifiers will allow the claim to be submitted for payment and will not count toward the beneficiary's yearly EPSDT periodic complete medical screening limits.

Procedure codes**,** in conjunction with the **EP and H9 modifiers,** are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system.

215.100 Schedule for Child Health Services (EPSDT) Medical/Periodicity Screening 2-1-22

The periodic EPSDT screening schedule has been changed in accordance with the most recent recommendations of the American Academy of Pediatrics.

From birth to 15 months of age, children may receive six (6) periodic screens in addition to the newborn screen performed in the hospital.

Children age 15 months to 24 months of age may receive two (2) periodic screens. Children age 24 months to 30 months may receive one (1) periodic screen, and children 30 months to 3 years old may receive one (1) periodic screen.

When a child has turned 3 years old, the following schedule will apply. There must be at least 365 days between each screen listed below for children age 3 years through 20 years.

Age			
3 years	8 years	13 years	18 years
4 years	9 years	14 years	19 years
5 years	10 years	15 years	20 years
6 years	11 years	16 years	
7 years	12 years	17 years	

Most medical and hearing screens for children require a PCP referral before the screens may occur. Routine newborn care, vision screens, dental screens and immunizations for childhood diseases do not require PCP referral. See **Section 242.100** for procedure codes.

215.210 Health and Developmental History 2-1-22

A health and developmental history should be obtained from the parent or other responsible adult who is familiar with the child's health history. The child's height and weight should also be

recorded and compared with the ranges considered normal for children of that age. See **Section 242.100** for procedure codes.

215.220 Unclothed Physical Examination 2-1-22

An unclothed physical examination should be performed to note obvious physical defects including orthopedic, genital, skin, and other observable deviations. If there is evidence that the child has been physically abused, this should be reported to the authorities according to state law requirements. See **Section 242.100** for procedure codes.

215.230 Developmental Assessment 2-1-22

A developmental assessment should be obtained by history and observation of the child or by one of the developmental tests. This portion of the screening could include assessment of eye-hand coordination, gross motor function (walking, hopping, climbing), fine motor skills (use of finger dexterity and hand usage), speech development, daily living personal skills such as dressing, feeding and grooming oneself, behavioral development and proofs of mind with body integration. See **Section 242.100** for procedure codes.

215.240 Visual Evaluation 2-1-22

A visual evaluation is required for all children receiving Child Health Services (EPSDT) screening. The age-specific procedures (Section 216.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require Titmus machine or other ophthalmological testing. Subjective testing may be provided as part of a vision screening. See **Section 242.100** for procedure codes.

215.250 Hearing Evaluation 2-1-22

A hearing evaluation is required for all children receiving a Child Health Services (EPSDT) screening. The age-specific procedures (Section 217.000) may be helpful to determine the necessary procedures according to the child's age. This screening does not require machine audiology testing. Subjective testing may be provided as part of a hearing screening. See **Section 242.100** for procedure codes.

215.260 Oral Assessment 2-1-22

An oral assessment is considered part of the full Child Health Services (EPSDT) screening. A referral to a dentist for an oral screen is offered beginning at childbirth. See **Section 242.100** for procedure codes.

215.270 Laboratory Procedures (CPT Codes) 2-1-22

Laboratory procedures should be performed as appropriate for the child's age and population group. See Sections 215.310 through 215.340 for age and testing recommendations. See Section 219.000 for specific blood lead testing and **Section 242.150** for CPT codes.

215.280 Nutritional Assessment 2-1-22

Physical and laboratory determinations carried out in the screening process will usually yield information useful in assessing nutritional status. A child having any detectable nutritional deficiencies should be treated or referred to the proper resource for counseling. This component of the medical screen is included in the full Child Health Services (EPSDT) screening. See **Section 242.100** for procedure codes.

215.290 Health Education 2-1-22

Health education is a required component of screening services and includes anticipatory guidance. The developmental assessment, comprehensive physical examination, visual, hearing or dental screening provides the initial opportunity for providing health education. Health education and counseling to parents (or guardians) and children are required. Health education and counseling are designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. See **Section 242.100** for procedure codes.

Health education can include but isn't limited to tobacco cessation counseling services to the parent/legal guardian of the child.

A. Counseling Visits:

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

* Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Referral of patient to an intensive tobacco cessation referral program.

C. Can be billed in addition to an office visit or EPSDT.

D. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

E. These counseling sessions do NOT require a PCP referral.

F. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**.

Refer to Section 257.000 and Section 292.900 of the Physician's manual for more information.

216.000 Vision Screen 2-1-22

An EPSDT periodic complete medical screen includes both hearing and vision screens. Providers must not bill an EPSDT periodic vision or hearing screen on the same day, or within seven (7) days of an EPSDT periodic complete medical screen by the same or different providers. The above combinations represent a duplication of services.

The provider must administer an age-appropriate vision assessment. See **Section 242.100** for procedure codes.

Vision services are subject to their own periodicity schedule; however, when the periodicity schedule coincides with the schedule for periodic complete medical screen, vision screens must be included as part of the required minimum periodic complete medical screening services. Vision screens are exempt from the PCP referral requirement.

See Sections 215.310 through 215.340 for the age-specific vision screening periodicity schedule.

At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses.

218.000 Dental Screening Services 2-1-22

Although an oral assessment may be part of a medical screen, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child once per state fiscal year (July 1 through June 30). See **Section 242.100** for procedure codes.

A Child Health Services (EPSDT) interperiodic dental screen may be completed as often as medically necessary, but must be prior authorized in order for the claim to be paid. Refer to Section 220.000 for an explanation of the prior authorization process.

Dental screens are exempt from the primary care provider (PCP) referral requirement.

Dental Services
At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. The periodicity schedule for other EPSDT services may not govern the schedule for dental services.

A child should receive his or her first dental screen examination within 6 months after eruption of the first primary tooth but no later than 12 months of age.

220.000 PRIOR AUTHORIZATION 1-1-22

Prior authorization is required for the interperiodic dental screen and must be requested on the ADA claim form. Refer to the Dental Provider Manual for details regarding the prior authorization process. See **Section 242.100** for procedure codes.

242.100 Procedure Codes 2-1-22

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

[1] Exempt from PCP referral requirements
[2] Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

NOTES

A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.

B. New born screenings can be performed by a Certified Nurse Midwife or Nurse Practitioner without a PCP referral.

C. Procedure codes, used in conjunction with the **EP and H9 modifiers,** are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)

D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. M**ay be billed on the CMS-1500 claim form, by paper or electronically. (View or print a CMS-1500 sample form.)** M**ay also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**

E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.

F. Immunizations and laboratory tests may be billed separately from comprehensive screens.

G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.

H. May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections ONLY when the provider administers, but does not supply the drug.

1. Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
2. Cannot be billed to administer any medication given for family planning purposes.
3. Cannot be billed when the drug administered is not FDA approved.

I. Procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Claims require National Place of Service code “11”. Procedure code is limited to beneficiaries under age twenty-one (21).

242.110 Newborn Care 2-1-22

For routine newborn care following a vaginal delivery or C-section, procedure code should be used one time to cover all newborn care visits by the attending physician. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

These procedure codes include the physical exam of the baby and the conference(s) with the newborn’s parent(s), which is considered to be the initial newborn care/EPSDT screen in hospital. These procedure codes should not be used for illness care (e.g. neonatal jaundice). Providers may refer to the physician manual for necessary illness codes.

Note the descriptions, modifiers, and required diagnosis range. The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis for all providers **(View ICD Codes.)** Refer to the appropriate manual(s) for additional information about newborn screenings.

242.120 Billing Exceptions 2-1-22

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

All EPSDT procedure codes must be billed on the CMS-1500 claim form with the following exceptions.

A. Dental Billing

1. Procedure code must be billed on the American Dental Association (ADA) claim form. **View or print the ADA claim form.**
2. Prior authorization for procedure code must be requested on the ADA claim form.
3. Procedure code for an interperiodic dental screen must be billed on the ADA claim form.

B. When billing EPSDT screening codes, providers are not limited to the following diagnosis codes: **(View ICD Codes.)** The newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis **(View ICD Codes.)**

242.140 Vaccines for Children Program 2-1-22

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. To enroll in the VFC Program, contact the Arkansas Department of Health. Providers may also obtain the vaccines to administer from the Arkansas Department of Health. **View or print Arkansas Department of Health contact information.**

Vaccines available through the VFC program are covered for Medicaid-eligible children. Only the administrative fee is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ**.

All procedure codes under the VFC program must be billed electronically or on paper, using either the CMS-1500 claim form or the CMS-1450 claim form.

Medicaid policy regarding immunizations for adults remains unchanged by the VFC program.

Providers may consult the Physician's manual to view the list of vaccines that are non-VFC but are covered for beneficiaries who are 19 and 20 years of age. The following list contains the vaccines available through the VFC program.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

242.141 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas

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

2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

242.150 Limitation for Laboratory Procedures Performed as Part of EPSDT Screens 2-1-22

Child Health Services (EPSDT) screens do not include laboratory procedures unless the screen is performed by the beneficiary's primary care physician (PCP) or is conducted in accordance with a referral from the PCP.

The following tests are exempt from this limitation and may continue to be billed in conjunction with an EPSDT screen performed in accordance with existing Medicaid policy:

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Claims for laboratory tests, other than those specified above, performed in conjunction with an EPSDT screen will be denied, unless the screen is performed by the PCP or in accordance with a referral from the PCP.

The following screens will be affected by this policy.

242.300 Billing Instructions – Paper Only 2-1-22

To bill for a Child Health Services (EPSDT) screening service, use the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. **View or print a sample CMS-1500 form.**

Each screening should be billed separately, providing the appropriate information for each of the screening components.

View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

With the exception of codes (office medical services), (home medical services) and (hospital inpatient medical services), specific procedures may be used at the provider's discretion as long as the federally-mandated components (refer to Section 215.000) have been included in the screening package.

Medical services such as immunizations and laboratory procedures may also be billed on the CMS-1500 when provided in conjunction with a Child Health Services (EPSDT) screening, as well as other treatment services provided.

Claims for Child Health Services (EPSDT) dental services are to be billed on the ADA claim form. For dental screening to be paid, the ADA claim form must be completed and the box marked "child" in Field 2 must be checked.

Claims for Child Health Services (EPSDT) visual services are to be billed on the CMS-1500 claim form. The numbered items correspond to numbered fields on the claim form. See Section 242.310 for paper billing instructions. **View or print a sample CMS-1500 form.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness and clarity are essential. Claims cannot be processed if applicable information is omitted. Claims should be typed whenever possible.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

TOC not required

262.110 FQHC Encounter Service 2-1-22

FQHCs bill Medicaid for a core services encounter (which includes all services and supplies incident to the encounter) with procedure code, "FQHC Encounter Service."

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

Use type of service code 9 (paper claims only) with. Medicaid pays the facility's current established rate for each encounter.

262.120 Telemedicine 2-1-22

Use procedure code and type of service code Y (paper claims only) to indicate telemedicine charges.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

The charge associated with this procedure code should be an amount attributable to the telemedicine service, such as line (or wireless) charges. Medicaid will deny the charge and capture it in the same manner as with ancillary charges.

262.130 Obstetric and Gynecologic Encounters 2-1-22

Bill for the following obstetric and gynecologic procedures with the CPT procedure codes indicated and type of service code 2 (paper claims only).

View or print the procedure codes for Federally Qualified Health Center (FQHC) services. For settlement purposes, each of these procedures is considered an encounter.

262.140 Family Planning 2-1-22

Bill Medicaid for family planning services with applicable procedure codes listed in Sections **262.141** through **262.152**.

262.141 Family Planning and Post-Sterilization Visits 2-1-22

Bill for family planning visits and post-sterilization visits with type of service code A (paper billing only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.142 Family Planning Procedures 2-1-22

Bill for family planning procedures with a type of service code A (paper billing only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.143 Contraceptives 2-1-22

Bill for contraceptives with type of service code A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.144 Contraceptive Injections—Depo-Provera 2-1-22

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.151 Local Procedure Codes 2-1-22

Bill for family planning laboratory procedures with type of service code A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.152 National Procedure Codes 2-1-22

Bill for family planning laboratory procedures with a type of service A (paper claims only) and a family planning diagnosis.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

262.442 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes for Federally Qualified Health Center (FQHC) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

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

TOC not required

242.100 Audiology Procedure Codes 2-1-22

Use the following procedure codes for audiological function tests.

View or print the procedure codes for Hearing (Audiology) services.

† Non-payable to a school district or ESC

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

Use the following procedure code for hearing screenings for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

242.110 Hearing Aid Procedure Codes 2-1-22

Use the following procedure codes for hearing aid equipment for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

View or print the procedure codes for Hearing (Audiology) services.

Medicaid covers up to 2 hearing aids per beneficiary each six-months. Hearing aid procedure codes may be billed electronically or on a paper claim form.

*Repairs require prior authorization
**Accessories
† Non-payable to a school district or ESC

242.400 Special Billing Procedures 2-1-22

Requests for payment of hearing aids, accessories and repairs must be completed on Form CMS-1500 prior to being submitted to the Utilization Review Section.

The following documentation must accompany each request for a hearing aid:

A. Medical Clearance (within the last six (6) months, by an orologist or ENT specialist)

B. Audiogram (by certified audiologist) and Evaluation

All hearing aid providers must use code (Hearing Aid Repair and Service) when billing for hearing aid repairs.

View or print the procedure codes for Hearing (Audiology) services.

Code will require authorization prior to payment. All prior authorization requests must be submitted to the Hearing Aid Consultant, Division of Medical Services. **View or print the Division of Medical Services Hearing Aid Consultant contact information.**

Use code when billing for hearing aid accessories.

TOC not required

242.110 Home Health Visits 2-1-22

View or print the procedure codes for Home Health services.

242.120 Home Health Physical Therapy 2-1-22

View or print the procedure codes for Home Health services.

242.130 Specimen Collection 2-1-22

View or print the procedure codes for Home Health services.

A. Venipuncture (drawing blood to obtain a blood sample) and catheterization to collect urine specimens are excluded from the eligibility criteria for intermittent skilled nursing services under the home health benefit.

B. When venipuncture to obtain a blood sample or catheterization to collect a urine specimen is the only skilled service that is needed by the patient, that individual does not qualify for skilled services.

242.141 Epogen Injections for Renal Failure 2-1-22

View or print the procedure codes for Home Health services.

242.142 Epogen Injections for Diagnosis other than Renal Failure 2-1-22

View or print the procedure codes for Home Health services.

242.144 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

View or print the procedure codes for Home Health services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

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

242.150 Home Health Medical Supplies 2-1-22

The following Health Care Procedural Coding System (HCPCS) codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers must use the current HCPCS Book for code descriptions.

View or print the procedure codes for Home Health services.

Listed below are medical supplies that require special billing or need prior authorization. These items are listed with the HCPCS codes and require modifiers. The asterisk denotes these items and the required modifiers.

A. *Home Blood Glucose Supplies – Pregnant Women Only, All Ages

Codes must be billed either electronically or on paper with modifier NU for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the NU modifier.

B. **Gradient Compression Stocking (Jobst Stocking), All Ages

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. Before supplying the items, the Jobst stocking must be prior authorized by AFMC. **View or print form DMS-679A and instructions for completion.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stocking and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy.

Code must be manually priced.

Code requires a prior authorization (PA). See Section 221.000.

Code requires prior authorization (PA); see Section 221.000. Code is manually priced and is covered for beneficiaries ages 0-20 years of age.

C. ***Food Thickeners, All Ages

Food thickeners, including "Thick-it", "Simple Thick", "Thick and Easy" and "Thick and Clear" are not subjected to the medical supply benefit limit.

The modifier **NU** must be used with the code found in this section and when food thickeners are administered enterally, the modifier **"BA"** must be used in conjunction with the code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may be rounded up. When a date span is billed, the product cannot be billed until the end date of the span has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

The following HCPCS codes usage must match the Arkansas Medicaid code description and use of modifier(s).

*The following HCPCS codes and modifiers are covered only for pregnant women.

242.160 Incontinence Supplies 2-1-22

Codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

View or print the procedure codes for Home Health services.

Reimbursement is based on a per unit basis with one unit equaling one item (diaper or underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Provider may not bill “from” and “through” dates of services.

TOC required

216.300 Hysteroscopy for Foreign Body Removal 2-1-22

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

Procedure code requires paper billing and clinical documentation for justification.

216.540 Family Planning Procedures 2-1-22

The following procedure code table lists family planning procedures payable to hospitals. These codes require a primary diagnosis of family planning on the claim.

Sterilization procedures require paper billing with DMS-615 attached. **View or print form DMS-615. View or print form DMS-615 Spanish.**

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

*CPT code represents a procedure to treat medical conditions as well as for elective sterilizations.

Family planning laboratory codes are found in **Section 216.550**.

216.550 Family Planning Lab Procedures 2-1-22

Family planning services are covered for beneficiaries in full coverage for Aid Category 61 (PW-PI). For additional information on Family Planning Services, see Sections 216.100-216.110, 216.130-216.132, 216.515, and 216.540-216.550.

Collection fees for laboratory procedures are included in the reimbursement for the laboratory procedure.

The following procedure codes table lists payable family planning laboratory procedure codes that require a primary diagnosis of Family Planning on the claim form:

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.*Procedure codes are limited to one unit per beneficiary per state fiscal year.

217.062 Corneal Transplants 2-1-22

A. Medicaid covers hospitalization related to corneal transplants from the date of the transplant procedure until the date of discharge, subject to the beneficiary's inpatient benefit utilization status if he or she is aged 21 or older and subject to MUMP precertification requirements.

B. Coverage includes the preservation of the organ from a cadaver donor but not the harvesting of the organ.

C. For processing, preserving and transporting corneal tissues, use procedure code. Requires paper billing and a manufacturer's invoice attached to the claim.

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

217.090 Bilaminate Graft or Skin Substitute Coverage Restriction 2-1-22

A. Indications and Documentation:

When the diagnosis is a burn injury (**View ICD Codes.**) (indicated on the claim form), no additional medical treatment documentation is required.

This modality/product will be covered for other restricted diagnoses (indicated below) when all of the following provisions are met and are documented in the beneficiary's medical record:

1. Partial or full-thickness skin ulcers due to venous insufficiency or full-thickness neuropathic diabetic foot ulcers,
2. Ulcers of more than three (3) months duration and
3. Ulcers that have failed to respond to documented conservative measures of more than two (2) months duration.
4. There must be measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment.
5. For neuropathic diabetic foot ulcers, appropriate steps to off-load pressure during treatment must be taken and documented in the patient's medical record.
6. The ulcer must be free of infection and underlying osteomyelitis; treatment of the underlying disease (e.g., peripheral vascular disease) must be provided and documented in conjunction with skin substitute treatment.

B. Diagnosis Restrictions:

Coverage of the bilaminate skin product and its application is restricted to the diagnosis represented by the following ICD codes:

(**View ICD Codes**.)

C. Outpatient Billing:

The manufactured viable bilaminate graft or skin substitute product is manually priced. It must be billed to Medicaid by paper claim with procedure code. The manufacturer's invoice, the wound size description and the operative report must be attached.

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

Outpatient procedures to apply bilaminate skin substitute are payable using the appropriate procedure code(s). These codes must be listed separately when filing claims and may be billed electronically.

217.113 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

A. Arkansas Medicaid covers wireless endoscopy capsule for diagnosis of occult gastrointestinal bleeding in the anemic patient under the conditions listed below.

1. The site of the bleeding has not been identified by previous gastrointestinal endoscopy, colonoscopy, push endoscopy or other radiological procedures.
2. An abnormal x-ray of the small intestine is documented without an identified site of bleeding by endoscopic means.
3. Diagnosis of angiodysplasias of the GI tract is suspected, or
4. Individuals with confirmed Crohn's disease to determine whether there is involvement of the small bowel.

B. This procedure is covered for individuals of all ages based on medical necessity when performed with FDA-approved devices and by providers formally trained in upper and lower endoscopies.

C. Documentation of medical necessity requires a primary diagnosis of one of the following ICD diagnosis codes: (**View ICD Codes**.)

D. GI tract capsule endoscopy is not covered in the patient who has not undergone upper GI endoscopy and colonoscopy during the same period of illness in which a source of bleeding is not revealed.

E. This test is covered only for those beneficiaries with documented continuing blood loss and anemia secondary to bleeding.

F. See **Section 272.405** for procedure code and billing instructions

217.141 Computed Tomographic Colonography (CT Colonography) 2-1-22

A. The following procedure codes are covered for 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 and/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 an obstruction neoplasm, spasm, 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 signs of 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 (e.g., biopsy) or for treatment (e.g., polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.
   d. CT colonography procedure codes are counted against the beneficiary's annual lab and X- Ray benefit limit.
   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. Claims submitted without ICD codes coded to the highest level of specificity will be denied.
2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography), which was incomplete, must be retained in the patient's record.
3. The patient's medical record must include the following and be available upon request:
    a. The order/prescription from the referring physician
    b. Description of polyps/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. 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)
        incompletely characterized lesions
        (e.g.) hypodense renal or liver lesion
        v. E4 – Clinically important findings (work-up needed)
        (e.g.) solid renal or liver mass, aortic aneurysm, adenopathy
    e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy which was incomplete due to obstruction.

244.000 Procedures that Require Prior Authorization 2-1-22

A. The procedures represented by the CPT and HCPCS codes in the following table require prior authorization (PA). The performing physician or dentist (or the referring physician or

dentist, when lab work is ordered or injections are given by non-physician staff) is responsible for obtaining required PA and forwarding the PA control number to appropriate hospital staff for documentation and billing purposes. A claim for any hospital services that involve a PA-required procedure must contain the assigned PA control number or Medicaid will deny it. (See Sections 241.000 through 244.000 of this manual for instructions for obtaining prior authorization.)

See Section 272.449 for billing instructions for Molecular Pathology codes.

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

B. For inpatient hospital facility abortion claims, the provider claim must use the following codes:

1. 10A00ZZ Abortion of Products of Conception, Open Approach
2. 10A03ZZ Abortion Products of Conception, Percutaneous Approach
3. 10AO7Z6 Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
4. 10A07ZW Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
5. 10A07ZX Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
6. 10A07ZZ Abortion of Products of Conception, Via Natural or Artificial Opening

C. The following outpatient hospital abortion procedure codes will require PA:

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

245.031 Prior Authorization of Hyaluronon (Sodium Hyaluronate) Injection 2-1-22

Prior authorization is required for coverage of the Hyaluronon (sodium hyaluronate) injection. Providers must specify the brand name of Hyaluronon (sodium hyaluronate) or derivative when requesting prior authorization for the following procedure codes:

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

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

The request must include the patient's name, Medicaid ID number, physician's name, physician's provider identification number, patient's age, and medical records that document the severity of osteoarthritis, previous treatments and site of injection. Hyaluronon is limited to one series of injections per knee, per beneficiary, per lifetime.

252.117 Reimbursement of Burn Dressing Changes in Outpatient Hospitals 2-1-22

A. The CPT procedure codes for burn dressing changes are in the range of surgical procedures, but the Arkansas Medicaid Program has deemed them therapy procedures for reimbursement purposes. They are not listed in the outpatient surgical groupings.

B. Burn dressing changes are reimbursed at a global fee. The global fee includes:

1. All medication, pre-medication, I.V. fluids, dressing solutions and topical applications,
2. All dressings and necessary supplies and
3. All room charges.

C. Conform to the following procedure code definitions when billing for burn dressing changes:

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

D. Medicaid allows reimbursement for only one burn dressing change procedure per day.

E. Physical therapy charges are not included in the global fee.

1. Physical therapy requires a written prescription by the attending physician.
2. Physical therapy requires a PCP referral.
3. A copy of the attending physician's order reflecting the frequency of dressing changes and the mode(s) of therapy to be administered must be maintained in the patient's chart and must be available upon request by any authorized representative of Arkansas Division of Medical Services.

272.115 Observation Bed Billing Information 2-1-22

Use code 760* to bill for Observation Bed. One unit of service on the CMS-1450 (UB-04) outpatient claim equals 1 hour of service. Medicaid will cover up to 8 hours of hospital observation per date of service.

When a physician admits a patient to observation subsequent to providing emergency or non-emergency services in the emergency department, the hospital may bill the observation bed code 760* and the appropriate procedure code for emergency room 450* or non-emergency room 459*. Condition code 88 must be billed to indicate an emergency claim.

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

You may not bill 622* or 250*:

A. Alone or in conjunction with only one another.

B. With the non-emergency room procedure code 459*.

C. With an outpatient surgical procedure.

D. Without code 450*.

*Revenue code

272.131 Non-Emergency Charges 2-1-22

The following procedure codes may be billed in conjunction with procedure code 459* ("Other non-emergency service", which includes room charge). See Section 272.510 for billing requirements.

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

*Refer to Section 272.510 for additional criteria.

NOTE: Arkansas Medicaid reimburses for medically necessary vaccines, laboratory services, X-Rays and machine tests in addition to standalone revenue code 0459.

272.132 Procedure Codes Requiring Modifiers 2-1-22

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

272.404 Hyperbaric Oxygen Therapy (HBOT) Procedures 2-1-22

A. **Facilities may bill for only one unit of service per day.** The facility's charge for each service date must include all its hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

B. Facilities may bill for laboratory, X-ray, machine tests and outpatient surgery in addition to procedure code.

C. Hospitals and ambulatory surgical centers may bill electronically or file paper claims for procedure code with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

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

Refer to Sections 217.130, 242.000, 244.000, 245.030, and 252.119 for additional information on HBOT.

272.405 Billing of Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as, is payable for all ages and must be billed by using the primary diagnosis of (**View ICD Codes**.).

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

This procedure code should be billed with no modifiers when performed in the outpatient hospital place of service.

CPT code is payable on electronic and paper claims. For coverage policy, see Section 217.113.

272.421 Dialysis Procedure Codes 2-1-22

The facility providing the hemodialysis and peritoneal dialysis service must use the following HCPCS procedure codes when billing for the dialysis treatment:

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

The codes listed in CPT-4 must not be used.

National Code	Revenue Code Description
820*	Facility Fee-Hemodialysis (maximum - 3 treatments per week)
830*	Facility Fee - Peritoneal Dialysis (10-19 hours per week)
839*	Facility Fee - Peritoneal Dialysis (20-29 hours per week)
831*	Facility Fee - Peritoneal Dialysis (Weekly - Over 29 hours)

*Revenue code

272.435 Tissue Typing 2-1-22

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

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

B. The tissue typing is subject to the $500.00 annual lab and X-ray benefit limit.

1. Extensions will be considered for beneficiaries who exceed the $500.00 annual lab and X-ray benefit limit.
2. Providers must request an extension.

C. Medicaid will authorize up to 10 tissue-typing lab procedures to determine a match for an unrelated bone marrow donor.

272.436 Billing for Corneal Transplant 2-1-22

For processing, preserving and transporting corneal tissue, use procedure code

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

Requires paper billing and a manufacturer's invoice attached to the claim. See Section 217.062 for coverage information.

272.437 Vascular Embolization and Occlusion 2-1-22

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

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

272.440 Factor VIIa 2-1-22

Arkansas Medicaid covers Factor VIIa (coagulation factor, recombinant) for treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX. Factor VIIa coverage is restricted to diagnosis codes: (**View ICD Codes**.).

Providers must bill Medicaid for Factor VIIa with HCPCS procedure code. One unit equals 1.2 milligrams.

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

272.441 Factor VIII 2-1-22

HCPCS procedure code must be used when billing for all anti-hemophiliac Factor VIII, including Monoclate.

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

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.442 Factor IX 2-1-22

HCPCS procedure code must be used when billing for Factor IX Complex (Human).

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

Factor IX Complex (Human) is covered by the Arkansas Medicaid Program when administered in the outpatient hospital setting, physician's office or beneficiary's home. When billing for this procedure, enter the brand name and the dosage in the description area of the claim form. The provider must bill the cost per unit and the number of units administered. The number of units administered must be entered in the units column of the claim form.

272.443 Factor VIII and Factor IX 2-1-22

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician's office or in the patient's home. The following procedure codes must be used:

Factor VIII [antihemophilic factor (porcine)], per IU

Factor VIII [antihemophilic factor (recombinant)], per IU

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

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code must be used when billing for Factor IX Complex (human). Factor IX Complex (human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

For the purposes of Factor VIII and Factor IX coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

272.447 Bone Stimulation 2-1-22

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

Procedure codes are payable when provided in the physician's office, ambulatory surgical center or outpatient hospital setting to Medicaid beneficiaries of all ages. Procedure codes will require prior authorization and are payable only for non-union of bone. When provided in the outpatient setting, the provider must submit an invoice with the claim if providing the device.

272.448 Vascular Injection Procedures 2-1-22

Effective for claims with dates of service on or after December 1, 1993, in accordance with Medicare guidelines, the Arkansas Medicaid Program implemented the following policy regarding vascular injection procedures:

If a provider bills procedure code and one or all of the following procedure codes on the same date of service, the Medicaid Program will reimburse for procedure code and the other codes will be denied.

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

272.450 Special Billing Requirements for Laboratory and X-Ray Services 2-1-22

The following codes have special billing requirements for laboratory and X-Ray procedures.

A. CPT and HCPCS Lab Procedure Codes with Diagnosis Restrictions

The following CPT procedure codes will be payable with a primary diagnosis as is indicated below.

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

B. Genetic Testing

C. Arkansas Code §20-15-302 states that all newborn infants shall be tested for certain metabolic diseases. Arkansas Medicaid shall reimburse the enrolled Arkansas Medicaid hospital provider that performs the tests required for the cost of the tests. Newborn Metabolic Screenings performed inpatient are included in the interim per diem reimbursement rate and facility cost settlement. For Newborn Metabolic Screenings

performed in the outpatient setting (due to retesting or as an initial screening), Arkansas Medicaid will reimburse the hospital directly. For the screenings performed in the outpatient hospital setting, the provider will submit a claim using procedure code. All positive test results shall be sent immediately to the Arkansas Department of Health.

The list of metabolic diseases for which providers can bill under can be found within the **Arkansas Department of Health (ADH) rules pertaining to testing of newborn infants**.

272.453 Hysterectomy for Cancer or Dysplasia 2-1-22

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

Hospitals may use procedure code when billing for a total hysterectomy procedure when the diagnosis is cancer or severe dysplasia.

Procedure code does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1450. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

272.461 Verteporfin (Visudyne) 2-1-22

Verteporfin (Visudyne), HCPCS procedure code**,** is payable to outpatient hospitals when furnished to Medicaid beneficiaries of any age when the requirements identified in Section 217.140 are met.

A. Verteporfin administration may be billed separately from the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD diagnosis codes: (**View ICD Codes**.)

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

D. May be billed electronically or on a paper claim

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

272.462 Billing Protocol for Computed Tomographic Colonography (CT) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

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

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For coverage policy information, see Section 217.141 of this manual.

272.500 Influenza Virus Vaccines 2-1-22

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

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months of age, is covered through the Vaccines for Children (VFC) program.

1. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **SL**.
3. ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or Print the Department of Health contact information.**

B. Effective for dates of service on and after October 1, 2005, Medicaid covers procedure code, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

1. For children under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B participants, claims must be filed using modifier **SL**.
3. For individuals aged 19 and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B participants, the procedure code must be billed using modifier **SL**.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered.

1. Modifiers **EP** and **TJ** are required.
2. For ARKids First-B beneficiaries, use modifier **SL**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals aged 3 years and older, will continue to be covered.

1. When filing paper claims for Medicaid beneficiaries under age 19, use modifiers **EP** and **TJ**.
2. For ARKids First-B participants, use modifier **SL**.
3. No modifier is required for filing claims for beneficiaries aged 19 and older.

272.501 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 2-1-22

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

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

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

272.510 Injections, Radiopharmaceuticals and Therapeutic Agents 2-1-22

Intravenous administration of therapeutic agents is payable only if provided in an outpatient setting. Therapeutic injections should only be provided by facilities that have the capacity to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Reimbursement for supplies is included in the administration fee.

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

Use procedure code for IV infusion therapy. For additional hours, sequential and/or concurrent infusions, bill revenue code **0760** (for observation), up to 8 hours maximum per day. For monoclonal antibody intravenous infusion use procedure code**.**

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

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

A. Multiple units may be billed when applicable. Take home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

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

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

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

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

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

Tables of Payable Procedure Codes

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

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years(y) or months (m).
4. The **fourth** column indicates specific ICD-9-CM primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 241.000 for prior authorization.)

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

See Section 241.000 for prior authorization procedures.

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

List 003/103 diagnosis codes include: (View ICD Codes) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

TOC not required

242.110 Parenteral Hyperalimentation Services 2-1-22

One unit of service equals a half-liter of fluid and includes fluids and the equipment and supplies necessary for the administration of the fluids in the beneficiary's place of residence.

View or print the procedure codes for Hyperalimentation services.

242.120 Enteral (Sole Source) Formulae 2-1-22

The following pages provide the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

Modifiers in this section are indicated by the headings M1, M2, and M3.

Enteral formulae are divided into several categories. Each unit of service equals one-hundred (100) calories of formula. All supplies and equipment necessary to administer the nutrients in the beneficiary's place of residence, except the infusion pump and pump supply kit, are included in the unit description.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preference for formulae will not be considered for medical necessity.

A separate prior authorization must be obtained for the enteral infusion pump and the pump supply kit. The enteral infusion pump and the pump supply kit may be billed separately.

View or print the procedure codes for Hyperalimentation services.

Exceptions to Use of Formula

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk or soy protein; chronic diarrhea, short gut; cystic fibrosis, fat malabsorption due to GI, or liver disease.

D. Gerber Extensive HA – Allergy to milk or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome, known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD),

eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24 – Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid Program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

242.130 Pedia-Pop 2-1-22

The following procedure code must be utilized when billing for Pedia-Pop.

View or print the procedure codes for Hyperalimentation services.

Reimbursement for this product is the provider's cost plus ten percent (10%). Pedia-Pop is covered for eligible Medicaid beneficiaries of all ages. Pedia-Pop is only for oral consumption in frozen form and may not be appropriate for a hyperalimentation diet.

242.142 Equipment and Supplies for Enteral (Sole Source) Nutrition Therapy 2-1-22

Equipment and supplies necessary for the administration of enteral (sole source) nutrition therapy in the beneficiary's place of residence are included in the unit reimbursement price. Prior authorization is required for the enteral infusion pump and the pump supply kit and may be billed separately. The prior authorization request for the pump must contain supporting documentation to establish medical necessity (e.g., gravity feeding is not satisfactory due to aspiration, diarrhea, dumping syndrome, etc.).

Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column; if not, an "N" is shown.

View or print the procedure codes for Hyperalimentation services.

242.143 Reimbursement for the Enteral (Sole Source) Nutrition Infusion Pump 2-1-22

Reimbursement for the enteral (sole source) nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price

established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized.

View or print the procedure codes for Hyperalimentation services.

Procedure codes each represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan. Both codes are reimbursed on a per unit basis with 1 day equaling 1 unit of service.

The provider may bill for the infusion pump at a maximum of one (1) unit of service per day. Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for procedure codes. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

242.145 Equipment Repairs for the Enteral Nutrition Infusion Pump 2-1-22

Reimbursement for repairs of the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs are covered before the equipment becomes the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be mailed to the Utilization Review Section, Division of Medical Services as detailed in Section 220.000 of this manual. The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93.

Medicaid will not reimburse for additional repairs of an infusion pump after the provider has billed repair invoices totaling $290.93. If, after billing the Medicaid maximum allowed for repairs, the equipment is still not in proper working order, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code after receiving prior authorization for the new piece of equipment.

To bill the Medicaid Program for repairs made to the enteral infusion pump, use the following procedure code.

View or print the procedure codes for Hyperalimentation services.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the Arkansas Medicaid description.

242.402 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

   View or print the procedure codes for Hyperalimentation services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

TOC not required

214.500 Laboratory and X-Ray Services Referral Requirements 2-1-22

A nurse practitioner referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order,* pertinent supplemental diagnosis supporting the need for the test(s).

A. Diagnostic facilities, hospital labs and outpatient departments performing reference diagnostics rely on the referring nurse practitioner to establish medical necessity.

B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.

C. Nurse practitioners must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.

D. 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.

E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling and/or conveyance of specimens are as follows:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.620 Risk Management Services for High Risk Pregnancy 2-1-22

A nurse practitioner may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a nurse practitioner does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one service with a benefit limit of 32 cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional and psychosocial assessment by a nurse practitioner or a registered nurse on the nurse practitioner's staff, to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal and/or Newborn Record System or equivalent form includes:
    a. Medical history
    b. Menstrual history
    c. Pregnancy history
2. Nutritional assessment includes:
    a. 24 hour diet recall
    b. Screening for anemia
    c. Weight history
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: 2 units per pregnancy

B. Case Management Services

Case management services are provided by a nurse practitioner, a licensed social worker or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational and other services (e.g., locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist or health educator) include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy
6. Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within 72 hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.630 Fetal Non-Stress Test 2-1-22

The fetal non-stress test is *limited to 2 per pregnancy per beneficiary*. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity. Refer to Section 214.900 of this manual for procedures to request extension of benefits. Refer to **Section 252.451** of this manual for billing instructions and the procedure code.

The post-procedural visits are covered within the 10-day period following the fetal non-stress test.

215.000 Fluoride Varnish Treatment 2-1-22

Arkansas Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Nurse Practitioner services.

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at **http://ar.train.org**. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

252.110 Billing Protocol for Computed Tomographic Colonography (CT) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Nurse Practitioner services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Nurse Practitioner, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.130 Special Billing Instructions 2-1-22

A. Use the following procedure codes for billing.

View or print the procedure codes for Nurse Practitioner services.

B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology 2-1-22

The following Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Nurse Practitioner services.

252.132 Special Billing Requirements for Lab and X-Ray Services 2-1-22

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.

B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met in order for payment to be approved.

View or print the procedure codes for Nurse Practitioner services.

252.410 Clinic or Group Billing 2-1-22

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one nurse practitioner in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a nurse practitioner.

View or print the procedure codes for Nurse Practitioner services.

252.422 Detention Time (Standby Service) 2-1-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code must be used by nurse practitioners when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a nurse practitioner.

252.424 Hospital Discharge Day Management 2-1-22

View or print the procedure codes for Nurse Practitioner services.

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.426 Specimen Collections 2-1-22

The policy in regard to collection, handling and/or conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Nurse Practitioner services.

252.428 Services Not Considered a Separate Service from an Office Visit 2-1-22

Some services (e.g., pelvic examinations, prostatic massages, removal of sutures, etc.) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Nurse Practitioner services.

252.430 Family Planning Services Program Procedure Codes 2-1-22

A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and

claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**

C. The following procedure code table explains the family planning visit services payable to nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

View or print the procedure codes for Nurse Practitioner services.

D. The following procedure code table explains family planning codes payable to nurse practitioners. Use the FP modifier for family planning services.

*Bill using modifiers FP, SA.

**Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Use modifier FP for family planning services.

E. The following procedure codes are payable to Nurse Practitioners:

F. The following procedure code table explains the pathology procedure code payable to nurse practitioners.

NOTE: The procedure code with the modifiers indicated below denotes the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 252.431**.

252.431 Family Planning Laboratory Procedure Codes 2-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The following procedure code table contains family planning laboratory procedure codes.

View or print the procedure codes for Nurse Practitioner services.

*Procedure codes are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

¤See points B and C below for information regarding this procedure code.

B. Laboratory codes payable to **non-hospital-based nurse practitioners.**

The following procedure code table contains laboratory services payable to non-hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to **hospital-based nurse practitioners.**

The following procedure code table describes the laboratory services payable to hospital-based nurse practitioners.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

252.439 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes for Nurse Practitioner services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

252.441 Family/Group Psychotherapy 2-1-22

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Nurse Practitioner services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code is payable only when the patient is present during the treatment. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.443 Other Covered Injections 2-1-22

Nurse practitioners billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Nurse Practitioner services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 2-1-22

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Nurse Practitioner services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs 2-1-22

Effective for dates of service on and after **September 1, 2020**, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by providers who possess an X-DEA license on file with Arkansas Medicaid Provider Enrollment for billing purposes. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Nurse Practitioner services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

252.449 Influenza Virus Vaccine 2-1-22

View or print the procedure codes for Nurse Practitioner services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children 6 to 35 months, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, preservative free, for ages 3 years and older.

1. For individuals under 19 years of age, claims must be filed using modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. For individuals ages 19 and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals ages 5 through 49 who are not pregnant.

1. When filing claims for children 5 through18 years of age, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries ages 19 through 49.

D. Procedure code, influenza virus vaccine, split virus, for children ages 6 through 35 months, is covered. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals ages 3 years and older, will continue to be covered.

1. When filing paper claims for individuals under age 19, use modifiers **EP** and **TJ**.
2. For ARKids First-B beneficiaries, use modifier **TJ**.
3. No modifier is required for filing claims for beneficiaries aged 19 and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy 2-1-22

Covered nurse practitioner obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A nurse practitioner may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the nurse practitioner employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered to be one service and are limited to 32 cumulative units.

View or print the procedure codes for Nurse Practitioner services.

For an early discharge home visit, use one of the applicable CPT procedure codes.

252.451 Fetal Non-Stress Test 2-1-22

The Fetal Non-Stress Test (procedure code) is limited to 2 per pregnancy. If it is necessary to exceed this limit, the nurse practitioner must request an extension of benefits and submit documentation that establishes medical necessity.

View or print the procedure codes for Nurse Practitioner services.

252.452 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Nurse Practitioner services.

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a nurse practitioner.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care/screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (e.g., neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment 2-1-22

View or print the procedure codes for Nurse Practitioner services.

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under age twenty-one (21).

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services 2-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide

pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria.**

View or print the procedure codes for Nurse Practitioner services.

*Exempt from PCP referral requirements.

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **View or Print Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing 2-1-22

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the nurse practitioner. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See Glossary - Section IV - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Nurse Practitioner services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 2-1-22

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Nurse Practitioner services.

252.457 Procedures That Require Prior Authorization 2-1-22

A. The following procedure code requires prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 220.000 of this manual for prior authorization instructions.)

B. The following Molecular Pathology codes require prior authorization from AFMC.

View or print the procedure codes for Nurse Practitioner services.

252.462 Non-Emergency Services 2-1-22

Procedure code should be billed for a non-emergency nurse practitioner visit.

View or print the procedure codes for Nurse Practitioner services.

252.484 Injections, Therapeutic and/or Diagnostic Agents 2-1-22

Nurse practitioners shall administer injections, therapeutic and diagnostic agents in accordance with the rules set forth in the Arkansas Medicaid Physician's policy manual and within the scope of their practice guidelines.

View or print the procedure codes for Nurse Practitioner services.

TOC not required

213.000 Outpatient Behavioral Health Services Program Entry 2-1-22

Prior to continuing provision of Counseling Level Services, the provider must document medical necessity of Outpatient Behavioral Health Counseling Services. The documentation of medical necessity is a written intake assessment that evaluates the beneficiary's mental condition and, based on the beneficiary's diagnosis, determines whether treatment in the Outpatient Behavioral Health Services Program is appropriate. This documentation must be made part of the beneficiary's medical record.

The intake assessment, either the Mental Health Diagnosis, Substance Abuse Assessment, or Psychiatric Assessment, must be completed prior to the provision of Counseling Level Services in the Outpatient Behavioral Health Services program. This intake will assist providers in determining services needed and desired outcomes for the beneficiary. The intake must be completed by a mental health professional qualified by licensure and experienced in the diagnosis and treatment of behavioral health and/or substance use disorders.

View or print the procedure codes for OBHS services.

231.100 Prior Authorization 2-1-22

Prior Authorization is required for certain Outpatient Behavioral Health Services provided to Medicaid-eligible beneficiaries.

Prior Authorization requests must be sent to the DMS contracted entity to perform prior authorizations for beneficiaries under the age of 21 and for beneficiaries age 21 and over for services that require a Prior Authorization. **View or print current contractor contact information.** Information related to clinical management guidelines and authorization request processes is available at **current contractor's website**.

Procedure codes requiring prior authorization:

View or print the procedure codes for OBHS services.

231.300 Substance Abuse Covered Codes 2-1-22

Certain Outpatient Behavioral Health Services are covered by Arkansas Medicaid for an individual whose primary diagnosis is substance abuse. Independently Licensed Practitioners may provide Substance Abuse Service within the scope of their practice. Behavioral Health Agency sites must be licensed by the Divisions of Provider Services and Quality Assurance in order to provide Substance Abuse Services. Allowable substance abuse services are listed below:

View or print the procedure codes for OBHS services.

Beneficiaries being treated by an Outpatient Behavioral Health Service provider for a mental health disorder who also have a co-occurring substance use disorder(s), this (these) substance use disorder(s) is (are) listed as a secondary diagnosis. Outpatient Behavioral Health Service Agency providers that are certified to provide Substance Abuse services may also provider substance abuse treatment to their behavioral health clients. In the provision of Outpatient Behavioral Health mental health services, the substance use disorder is appropriately focused on with the client in terms of its impact on and relationship to the primary mental health disorder.

A Behavioral Health Agency and Independently Licensed Practitioner may provide substance abuse treatment services to beneficiaries who they are also providing mental health/behavioral health services to. In this situation, the substance abuse disorder must be listed as the secondary diagnosis on the claim with the mental health/behavioral health diagnosis as the primary diagnosis.

252.111 Individual Behavioral Health Counseling 2-1-22

<table>
<tr><th>CPT®/HCPCS PROCEDURE CODE</th><th colspan="2">PROCEDURE CODE DESCRIPTION</th></tr>
<tr><td>View or print the procedure codes for OBHS services.</td><td colspan="2">Psychotherapy, 30 min
Psychotherapy, 45 min
Psychotherapy, 60 min</td></tr>
<tr><th>SERVICE DESCRIPTION</th><th colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</th></tr>
<tr><td>Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse, and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.</td><td colspan="2">• Date of Service
• Start and stop times of face-to-face encounter with beneficiary
• Place of service
• Diagnosis and pertinent interval history
• Brief mental status and observations
• Rationale and description of the treatment used that must coincide with Mental Health Diagnosis
• Beneficiary's response to treatment that includes current progress or regression and prognosis
• Any revisions indicated for the diagnosis, or medication concerns
• Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive or crisis plans
• Staff signature/credentials/date of signature</td></tr>
<tr><th>NOTES</th><th>UNIT</th><th>BENEFIT LIMITS</th></tr>
<tr><td>Services provided must be congruent with the objectives and interventions articulated on the most recent Mental Health Diagnosis. Services must be consistent with established behavioral healthcare standards. Individual Psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.

This service is not for beneficiaries under the age of 4 except in documented exceptional cases. This service will require a Prior Authorization for beneficiaries under the age of 4.</td><td>30 minutes
45 minutes
60 minutes
View or print the procedure codes for OBHS services.</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED:
One encounter between all three codes.
YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):
Counseling Level Beneficiary: 12 encounters between all 3 codes</td></tr>
<tr><th>APPLICABLE POPULATIONS</th><th colspan="2">SPECIAL BILLING INSTRUCTIONS</th></tr>
<tr><td>Children, Youth, and Adults
Residents of Long Term Care Facilities</td><td colspan="2">A provider may only bill one Individual Behavioral Health Counseling Code per day per beneficiary.</td></tr>
</table>

	A provider cannot bill any other Individual Behavioral Health Counseling Code on the same date of service for the same beneficiary. For Counseling Level Beneficiaries, there are 12 total individual counseling encounters allowed per year regardless of code billed for Individual Behavioral Health Counseling unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of services for beneficiaries under age 4 must be trained and certified in specific evidence based practices to be reimbursed for those services o Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider o Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.112 Group Behavioral Health Counseling 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Group psychotherapy (other than of a multiple-family group)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary's treatment process, support his/her rehabilitation effort, and to minimize relapse. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.	• Date of Service • Start and stop times of actual group encounter that includes identified beneficiary • Place of service • Number of participants • Diagnosis • Focus of group

<table>
<tr><td>Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</td><td colspan="2">Brief mental status and observations
Rationale for group counseling must coincide with Mental Health Assessment
Beneficiary's response to the group counseling that includes current progress or regression and prognosis
Any changes indicated for diagnosis, or medication concerns
Plan for next group session, including any homework assignments and/ or crisis plans
Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This does NOT include psychosocial groups. Beneficiaries eligible for Group Behavioral Health Counseling must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):

Counseling Level Beneficiary: 12 encounters</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one Group Behavioral Health Counseling encounter per day. For Counseling Level Beneficiaries, there are 12 total group behavioral health counseling encounters allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
</table>

• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 11 (Office), 49 (Independent Clinic), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substances Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.113 Marital/Family Behavioral Health Counseling with Beneficiary Present 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Family psychotherapy (conjoint psychotherapy) (with patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized and is only available for beneficiaries in Tier 1. Dyadic Infant/Caregiver Psychotherapy is a behaviorally based therapy that involves improving the parent-child relationship by transforming the interaction between the two parties. The primary goal of Dyadic Infant/Parent Psychotherapy is to strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief mental status of beneficiary and observations of beneficiary with spouse/family • Rationale for, and description of treatment used that must coincide with the Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the diagnosis, or medication concerns • Plan for next session, including any homework assignments and/or crisis plans • Staff signature/credentials/date of signature • HIPAA compliant Release of Information, completed, signed and dated

improving the child's cognitive, behavioral, and social functioning. This service uses child directed interaction to promote interaction between the parent and the child in a playful manner. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Child-Parent Psychotherapy (CPP) and Parent Child Interaction Therapy (PCIT).		
NOTES	**UNIT**	**BENEFIT LIMITS**
Natural supports may be included in these sessions if justified in service documentation and if supported in the documentation in the Mental Health Diagnosis. Only one beneficiary per family per therapy session may be billed.	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiaries: 12 encounters
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Patient encounter per day. There are 12 total Marital/Family Behavioral Health Counseling with Beneficiary Present encounters allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid. **The following codes cannot be billed on the Same Date of Service:** Multi-Family Behavioral Health Counseling Marital/Family Behavioral Health Counseling without Beneficiary Present –Psychoeducation **View or print the procedure codes for OBHS services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	

• Independently Licensed Clinicians - Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.114 Marital/Family Behavioral Health Counseling without Beneficiary Present 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Family psychotherapy (without the patient present)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Marital/Family Behavioral Health Counseling without Beneficiary Present is a face-to-face treatment provided to one or more family members outside the presence of a beneficiary. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary or family member(s), client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.	• Date of Service • Start and stop times of actual encounter spouse/family • Place of service • Participants present and relationship to beneficiary • Diagnosis and pertinent interval history • Brief observations with spouse/family • Rationale for, and description of treatment used that must coincide with the Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis • Any changes indicated for the diagnosis, or medication concerns

<table>
<tr><td></td><td colspan="2">

- Plan for next session, including any homework assignments and/or crisis plans
- Staff signature/credentials/date of signature
- HIPAA compliant Release of Information, completed, signed and dated

</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>Natural supports may be included in these sessions if justified in service documentation and if supported in Mental Health Diagnosis. Only one beneficiary per family per therapy session may be billed.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested):

Counseling Level Beneficiaries: 12 encounters</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one Marital / Family Behavioral Health Counseling with (or without) Beneficiary encounter per day.

The following codes cannot be billed on the Same Date of Service:
Multi-Family Behavioral Health Counseling
Marital/Family Behavioral Health Counseling with Beneficiary Present
–Psychoeducation
View or print the procedure codes for OBHS services.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>

- Independently Licensed Clinicians - Master’s/Doctoral
- Non-independently Licensed Clinicians – Master’s/Doctoral
- Advanced Practice Nurse
- Physician

</td><td colspan="2">03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient’s Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)</td></tr>
</table>

252.115 Psychoeducation 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Psychoeducational service; per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Psychoeducation provides beneficiaries and their families with pertinent information regarding mental illness, substance abuse, and tobacco cessation, and teaches problem-solving, communication, and coping skills to support recovery. Psychoeducation can be implemented in two formats: multifamily group and/or single family group. Due to the group format, beneficiaries and their families are also able to benefit from support of peers and mutual aid. Services must be congruent with the age and abilities of the beneficiary, client-centered, and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. Dyadic treatment must be prior authorized. Providers must utilize a national recognized evidence based practice. Practices include, but are not limited to, Nurturing Parents and Incredible Years.**	• Date of Service • Start and stop times of actual encounter with beneficiary and spouse/family • Place of service • Participants present • Nature of relationship with beneficiary • Rationale for excluding the identified beneficiary • Diagnosis and pertinent interval history • Rationale for and objective used that must coincide with Mental Health Diagnosis and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family. • Spouse/Family response to treatment that includes current progress or regression and prognosis • Any changes indicated diagnosis, or medication concerns • Plan for next session, including any homework assignments and/or crisis plans • HIPAA compliant Release of Information forms, completed, signed and dated • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Information to support the appropriateness of excluding the identified beneficiary must be documented in the service note and medical record. Natural supports may be included in these sessions when the nature of the relationship with the beneficiary and that support's expected role in attaining treatment goals is documented. Only one beneficiary per family per therapy session may be billed.	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 48
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	

Children, Youth, and Adults	A provider can only bill a total of 48 units of Psychoeducation **The following codes cannot be billed on the Same Date of Service:** Marital/Family Behavioral Health Counseling with Beneficiary Present Marital/Family Behavioral Health Counseling without Beneficiary Present **View or print the procedure codes for OBHS services.**
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face Telemedicine (Adults, Youth, and Children)	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians - Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.116 Multi-Family Behavioral Health Counseling 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Multiple-family group psychotherapy
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Multi-Family Behavioral Health Counseling is a group therapeutic intervention using face-to-face verbal interaction between two (2) to a maximum of nine (9) beneficiaries and their	• Date of Service • Start and stop times of actual encounter with beneficiary and/or spouse/family

<table>
<tr><td>family members or significant others. Services are a more cost-effective alternative to Marital/Family Behavioral Health Counseling, designed to enhance members' insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services may pertain to a beneficiary's (a) Mental Health or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and family and provided with cultural competence.</td><td colspan="2">Place of service
Participants present
Nature of relationship with beneficiary
Rationale for excluding the identified beneficiary
Diagnosis and pertinent interval history
Rationale for and objective used to improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family.
Spouse/Family response to treatment that includes current progress or regression and prognosis
Any changes indicated for the master treatment plan, diagnosis, or medication(s)
Plan for next session, including any homework assignments and/or crisis plans
HIPAA compliant Release of Information forms, completed, signed and dated
Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>May be provided independently if patient is being treated for substance abuse diagnosis only. Comorbid substance abuse should be provided as integrated treatment utilizing Family Psychotherapy.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 12</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">There are 12 total Multi-Family Behavioral Health Counseling encounters allowed per year.

The following codes cannot be billed on the Same Date of Service:

Marital/Family Behavioral Health Counseling without Beneficiary Present

Marital/Family Behavioral Health Counseling with Beneficiary Present

Interpretation of Diagnosis

Interpretation of Diagnosis, Telemedicine

View or print the procedure codes for OBHS</td></tr>
</table>

	services.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians - Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.117 Mental Health Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for OBHS services.	Psychiatric diagnostic evaluation (with no medical services)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature, and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to: a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (plan of care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions • Treatment recommendations, and prognosis for treatment • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**

<table>
<tr><td>This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes

This service can be provided via telemedicine to beneficiaries only ages 21 and above.

*Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months & parent/caregiver. A Mental Health Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. This service must include an assessment of:
○ Presenting symptoms and behaviors;
○ Developmental and medical history;
○ Family psychosocial and medical history;
○ Family functioning, cultural and communication patterns, and current environmental conditions and stressors;
○ Clinical interview with the primary caregiver and observation of the caregiver-infant relationship and interactive patterns;
○ Child’s affective, language, cognitive, motor, sensory, self-care, and social functioning.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults

Residents of Long Term Care</td><td colspan="2">The following codes cannot be billed on the Same Date of Service:

Psychiatric Assessment

View or print the procedure codes for OBHS services.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face

Telemedicine (Adults Only)</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDER</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Independently Licensed Clinicians –</td><td colspan="2">02 (Telemedicine), 03 (School), 04 (Homeless</td></tr>
</table>

Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician • Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider	Shelter), 11 (Office) 12 (Patient's Home), 32 (Nursing Facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.118 Interpretation of Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures, or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Services pertain to a beneficiary's (a) Mental Health and/or (b) Substance Abuse condition Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face-to-face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the Mental Health Diagnosis • Participant(s) response and feedback • Recommendation for additional supports including referrals, resources and information • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary;	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT

the beneficiary and the parent(s) or guardian(s); or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other. This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record. ***Dyadic treatment is available for parent/caregiver & child for dyadic treatment of children age 0 through 47 months& parent/caregiver. Interpretation of Diagnosis will be required for all children through 47 months to receive services. This service includes up to four encounters for children through the age of 47 months and can be provided without a prior authorization. The Interpretation of Diagnosis is a direct service that includes an interpretation from a broader perspective the history and information collected through the Mental Health Diagnosis. This interpretation identifies and prioritizes the infant's needs, establishes a diagnosis, and helps to determine the care and services to be provided.**		MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): Counseling Level Beneficiary: 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** Psychoeducation Psychiatric Assessment Multi-Family Behavioral Health Counseling Substance Abuse Assessment **View or print the procedure codes for OBHS services.** This service can be provided via telemedicine to beneficiaries ages 18 and above. This service can also be provided via telemedicine to beneficiaries ages 17 and under with documentation of parental or guardian involvement during the service. This documentation must be included in the medical record.	

ALLOWED MODE(S) OF DELIVERY	TIER
Face-to-face Telemedicine Adults, Youth and Children	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**

• Independently Licensed Clinicians – Master's/Doctoral
• Non-independently Licensed Clinicians – Master's/Doctoral
• Advanced Practice Nurse
• Physician
• Providers of dyadic services must be trained and certified in specific evidence based practices to be reimbursed for those services
  ○ Independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
  ○ Non-independently Licensed Clinicians – Parent/Caregiver & Child (Dyadic treatment of Children age 0-47 months & Parent/Caregiver) Provider
	02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.119 Substance Abuse Assessment 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Alcohol and/or drug assessment
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Assessment is a service that identifies and evaluates the nature and extent of a beneficiary's substance abuse condition using the Addiction Severity Index (ASI) or an assessment instrument approved by DAABHS and DMS. The assessment must screen for and identify any existing co-morbid conditions. The assessment should assign a diagnostic impression to the beneficiary, resulting in a treatment recommendation and referral appropriate to effectively treat the condition(s) identified. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions

cultural competence.	• Current functioning and strengths in specified life domains • DSM diagnostic impressions • Treatment recommendations and prognosis for treatment • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
The assessment process results in the assignment of a diagnostic impression, beneficiary recommendation for treatment regimen appropriate to the condition and situation presented by the beneficiary, initial plan (provisional) of care and referral to a service appropriate to effectively treat the condition(s) identified. If indicated, the assessment process must refer the beneficiary for a psychiatric consultation	Encounter	DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults	**The following codes cannot be billed on the Same Date of Service:** Interpretation of Diagnosis **View or print the procedure codes for OBHS services.**	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Counseling	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)	

252.120 Psychological Evaluation 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing

<table>
<tr><td colspan="2"></td><td>the report.</td></tr>
<tr><td>SERVICE DESCRIPTION</td><td colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</td></tr>
<tr><td>Psychological Evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary’s emotional, personality, and psychopathology, e.g., MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary.

Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence

Medical necessity for this service is met when:
• the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions
• history and symptomatology are not readily attributable to a particular psychiatric diagnosis
• questions to be answered by the evaluation could not be resolved by a Mental Health Diagnosis or Psychiatric Assessment, observation in therapy, or an assessment for level of care at a mental health facility
• the service provides information relevant to the beneficiary’s continuation in treatment and assists in the treatment process</td><td colspan="2">• Date of Service
• Start and stop times of actual encounter with beneficiary
• Start and stop times of scoring, interpretation and report preparation
• Place of service
• Identifying information
• Rationale for referral
• Presenting problem(s)
• Culturally and age-appropriate psychosocial history and assessment
• Mental status/Clinical observations and impressions
• Psychological tests used, results, and interpretations, as indicated
• DSM diagnostic
• Treatment recommendations and findings related to rationale for service and guided by test results
• Staff signature/credentials/date of signature(s)</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This code may not be billed for the completion of testing that is considered primarily educational or utilized for employment, disability qualification, or legal or court related purposes.</td><td>60 minutes</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">used for first hour of service</td></tr>
</table>

	used for any additional hours of service View or print the procedure codes for OBHS services.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Licensed Psychologist (LP) • Licensed Psychological Examiner (LPE) • Licensed Psychological Examiner – Independent (LPEI)	03 (School), 11 (Office), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)

252.121 Pharmacologic Management 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Office or other outpatient encounter for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history, A detailed examination; Medical decision making of moderate complexity View or print the procedure codes for OBHS services.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Pharmacologic Management is a service tailored to reduce, stabilize or eliminate psychiatric symptoms with the goal of improving functioning, including management and reduction of symptoms. This service includes evaluation of the medication prescription, administration, monitoring, and supervision and informing beneficiaries regarding medication(s) and its potential effects and side effects in order to make informed decisions regarding the	• Date of Service • Start and stop times of actual encounter with beneficiary • Place of service (When 99 is used for telemedicine, specific locations of the beneficiary and the physician must be included) • Diagnosis and pertinent interval history

<table>
<tr><td>prescribed medications. Services must be congruent with the age, strengths, and accommodations necessary for disability and cultural framework.

Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence.</td><td colspan="2">• Brief mental status and observations
• Rationale for and treatment used that must coincide with the Psychiatric Assessment
• Beneficiary's response to treatment that includes current progress or regression and prognosis
• Revisions indicated for the diagnosis, or medication(s)
• Plan for follow-up services, including any crisis plans
• If provided by physician that is not a psychiatrist, then any off label uses of medications should include documented consult with the overseeing psychiatrist within 24 hours of the prescription being written
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>Applies only to medications prescribed to address targeted symptoms as identified in the Psychiatric Assessment.</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 12</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2"></td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face

Telemedicine (Adults, Youth, and Children)</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Advanced Practice Nurse
• Physician</td><td colspan="2">02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12 (Patient’s Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)</td></tr>
</table>

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Psychiatric diagnostic evaluation with medical services
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychiatric Assessment is a face-to-face psychodiagnostic assessment conducted by a licensed physician or Advanced Practice Nurse (APN), preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18). This service is provided to determine the existence, type, nature, and most appropriate treatment of a behavioral health disorder. This service is not required for beneficiaries to receive Counseling Level Services.	• Date of Service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • The interview should obtain or verify all of the following: 1. The beneficiary's understanding of the factors leading to the referral 2. The presenting problem (including symptoms and functional impairments) 3. Relevant life circumstances and psychological factors 4. History of problems 5. Treatment history 6. Response to prior treatment interventions 7. Medical history (and examination as indicated) • For beneficiaries under the age of 18 1. an interview of a parent (preferably both), the guardian (including the responsible DCFS caseworker) and/or the primary caretaker (including foster parents) in order to: a) Clarify the reason for the referral b) Clarify the nature of the current symptoms c) Obtain a detailed medical, family and developmental history. • Culturally and age-appropriate psychosocial history and assessment • Mental status/Clinical observations and impressions • Current functioning and strengths in specified life domains • DSM diagnostic impressions

<table>
<tr><td></td><td colspan="2">• Treatment recommendations
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).</td><td>Encounter</td><td>DAILY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF ENCOUNTERS THAT MAY BE BILLED (extension of benefits can be requested): 1</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults

Telemedicine (Adults, Youth, and Children)</td><td colspan="2">The following codes cannot be billed on the Same Date of Service:

Mental Health Diagnosis

View or print the procedure codes for OBHS services.</td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">Counseling</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>A. an Arkansas-licensed physician, preferably one with specialized training and experience in psychiatry (child and adolescent psychiatry for beneficiaries under age 18)

B. an Adult Psychiatric Mental Health Advanced Nurse Practitioner/Family Psychiatric Mental Health Advanced Nurse Practitioner (PMHNP-BC)

The PMHNP-BC must meet all of the following requirements:

A. Licensed by the Arkansas State Board of Nursing

B. Practicing with licensure through the American Nurses Credentialing Center

C. Practicing under the supervision of an Arkansas-licensed psychiatrist with whom the PMHNP-BC has a collaborative agreement. The findings of the Psychiatric Assessment conducted by the PMHNP-BC must be discussed with the supervising psychiatrist within 45 days of the beneficiary entering care. The</td><td colspan="2">02 (Telemedicine), 03 (School), 04 (Homeless Shelter), 11 (Office), 12, (Patient’s Home), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57 (Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic)</td></tr>
</table>

collaborative agreement must comply with all Board of Nursing requirements and must spell out, in detail, what the nurse is authorized to do and what age group they may treat. D. Practicing within the scope of practice as defined by the Arkansas Nurse Practice Act E. Practicing within a PMHNP-BC's experience and competency level	

255.001 Crisis Intervention **2-1-22**

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for OBHS services.	Crisis intervention service, per 15 minutes	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.) Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family.	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12

beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis within 7 days of provision of this service if provided to a beneficiary who is not currently a client. **View or print the procedure codes for OBHS services.** If the beneficiary cannot be contacted or does not return for a Mental Health Diagnosis appointment, attempts to contact the beneficiary must be placed in the beneficiary's medical record. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children, Youth, and Adults		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	Crisis	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral (must be employed by Behavioral Health Agency) • Advanced Practice Nurse • Physician (must be employed by Behavioral Health Agency)	03 (School), 04 (Homeless Shelter), 11 (Office) 12 (Patient's Home), 15 (Mobile Unit), 23 (Emergency Room), 33 (Custodial Care facility), 49 (Independent Clinic), 50 (Federally Qualified Health Center), 53 (Community Mental Health Center), 57(Non-Residential Substance Abuse Treatment Facility), 71 (Public Health Clinic), 72 (Rural Health Clinic), 99 (Other Location)	

255.003 Acute Crisis Units 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for OBHS services.	Behavioral Health; short-term residential
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over	

the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	Per Diem	• 96 hours or less per encounter • 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Acute Crisis Units must be certified by the Division of Provider Services and Quality Assurance as an Acute Crisis Unit Provider		
CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for OBHS services.	Behavioral Health; short-term residential	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Acute Crisis Units provide brief (96 hours or less) crisis treatment services to persons over the age of 18 who are experiencing a psychiatry- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services in a safe environment with psychiatry and/or substance abuse services on-site at all times as well as on-call psychiatry available 24 hours a		

day. Services provide ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.		
NOTES	**EXAMPLE ACTIVITIES**	
APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	Per Diem	• 96 hours or less per encounter • 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
N/A	21, 51, 55, 56	

255.004 Substance Abuse Detoxification 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**
View or print the procedure codes for OBHS services.	Alcohol and/or drug services; detoxification
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Substance Abuse Detoxification is a set of interventions aimed at managing acute intoxication and withdrawal from alcohol or other drugs. Services help stabilize beneficiaries by clearing toxins from the beneficiary's body. Services are short-term and may be provided in a crisis unit, inpatient, or outpatient setting, and may include evaluation, observation, medical monitoring, and addiction treatment. Detoxification seeks to minimize the physical harm caused by the abuse of substances and prepares the beneficiary for ongoing treatment.	
NOTES	**EXAMPLE ACTIVITIES**

APPLICABLE POPULATIONS	**UNIT**	**BENEFIT LIMITS**
Youth and Adults	N/A	• 1 encounter per month • 6 encounters per SFY
	PROGRAM SERVICE CATEGORY	
	Crisis Services	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	N/A	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
Substance Abuse Detoxification must be provided in a facility that is certified by the Division of Provider Services and Quality Assurance as a Substance Abuse Detoxification provider.	21 (Inpatient Hospital), 55 (Residential Substance Abuse Treatment Facility)	

TOC not required

242.110 Private Duty Nursing Services Procedure Codes 2-1-22

The following procedure codes are applicable when billing the Arkansas Medicaid Program for private duty nursing services.

View or print the procedure codes for Private Duty Nursing (PDN) services.

*Effective for dates of service on and after April 4, 2008 procedure code can be billed for a RN supervisory visit. The maximum time allowed for reimbursement per visit is 3 hours, with a maximum of 18 visits per state fiscal year. Supervisory visits (as defined by the Arkansas Department of Health Rules and Regulations for Home Health Agencies) must be face-to-face and provided in a setting approved for private duty nursing services (see Section 242.200). Beneficiaries receiving extended care will require no less frequency than every two weeks of supervision. For beneficiaries classified as stable or chronic (beyond the first 3 months of extended care), RN supervisory visits will be no less than every 30 days.

242.120 Simultaneous Care of Two Patients 2-1-22

When a private duty nurse is caring for two patients simultaneously in the same location, the following procedure codes are to be used for the care provided to the second patient:

View or print the procedure codes for Private Duty Nursing (PDN) services.

242.130 Medical Supplies Procedure Codes 2-1-22

The following HCPCS procedure codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers will use the current Health Care Procedural Coding System (HCPCS) Book for procedure code descriptions.

*Refer to **Section 242.430**.

Procedure codes shown below contain a modifier and an Arkansas Medicaid procedure code description.

View or print the procedure codes for Private Duty Nursing (PDN) services.

242.410 Private Duty Nursing Billing Procedures 2-1-22

Private duty nursing services (PDN) are billed on a per unit basis. One unit equals one hour. Arkansas Medicaid will reimburse for the actual amount of cumulative PDN time on a monthly basis. Service time of less than one hour will not be rounded up to a full hour. Attach supervisory visit billing information with supporting documentation and assessment with the monthly private duty nursing billing. No supervisory visits will be covered without first providing prior authorized private duty nursing services within the same month. Billing units are cumulative up to one hour for the duration of one month. Supervisory visits of less than an hour can be billed cumulatively on a monthly basis but any visit less than a unit (hour) cannot be rounded up. Providers must file separate claims indicating the number of hours for each patient.

Type of service code “1” must be used when filing paper claims. Public schools must use type of service code “S” when filing paper claims for beneficiaries under age 21.

Refer to Sections **242.110** and **242.120** for PDN procedure codes for single patient care and multiple patient care.

242.421 Simultaneous Care of Two Patients in the Beneficiaries’ Home or a DDS Facility 2-1-22

When a private duty nurse is caring for two patients simultaneously in a location other than a public school, Arkansas Medicaid reimburses 100% of the maximum allowable rate for the first patient and 50% of the maximum allowable rate for the second patient.

Providers must file separate claims indicating the number of hours of care for each patient.

Providers must request prior authorization for procedure codes.

View or print the procedure codes for Private Duty Nursing (PDN) services.

242.430 Private Duty Nursing Medical Supplies 2-1-22

Procedure code, with types of service "**S**" and "**1**", must be manually priced. Procedure code with a type of service of "**1**" requires a prior authorization (PA).

View or print the procedure codes for Private Duty Nursing (PDN) services.

Form DMS-679 may be used to request prior authorization. **View or print form DMS 679.**

TOC required

222.000 Fetal Non-Stress Test and Ultrasound Benefit Limits 2-1-22

The Arkansas Medicaid Program covers the Fetal Non-Stress Test and the Ultrasound when performed in conjunction with maternity care. Refer to **Section 292.673** of this manual for procedure codes.

A. The Ultrasound and Fetal Non-Stress Test have a benefit limit of two (2) per pregnancy.

B. Post-procedural visits are covered within the 10-day period following a fetal non-stress test.

If it is necessary to exceed the Medicaid established benefit limits, the physician must request extension of the benefit with documentation that justifies the need for additional tests and establishes medical necessity.

223.000 Injections 2-1-22

A. The Arkansas Medicaid Program applies benefit limits to some covered injections.

B. For information on coverage of injections, special billing instructions and procedure codes, refer to Sections **292.595** and **292.950** of this manual.

225.200 Computed Tomographic Colonography (CT Colonography) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center 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 and/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 an obstruction neoplasm, spasm, 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 signs or 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 (e.g. biopsy) or for treatment (e.g. polypectomy), virtual colonography is not reimbursable when

used as an alternative to an instrument/fiberoptic colonoscopy, even though performed for signs or symptoms of disease.

d. CT colonography procedure codes are counted against the beneficiary's annual lab and X- ray benefit limit.

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 the 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. Claims submitted without ICD codes coded to the highest level of specificity will be denied.

2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography) which was incomplete must be retained in the patient's record.

3. The patient's medical record must include the following and be available upon request:

a. The order/prescription from the referring physician

b. Description of polyps/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. 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); and

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)
incompletely characterized lesions
e.g., hypodense renal or liver lesion

v. E4 - Clinically important findings (work-up needed)
e.g., solid renal or liver mass, aortic aneurysm, adenopathy

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

E. See Section 292.603 for billing protocol.

241.000 Fluoride Varnish Treatment 2-1-22

Arkansas Medicaid will expand coverage for fluoride varnish application, ADA code, to physicians and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The online training course can be accessed at **http://ar.train.org**. The provider will need to maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

242.000 Dermatology 2-1-22

The Arkansas Medicaid Program covers CPT procedure code Actinotherapy (ultraviolet light). The physician must submit documentation with claim to establish medical necessity.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

247.200 Risk Management Services for Pregnancy 2-1-22

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in the service descriptions below. If a physician does not choose to provide risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy.

Each of the covered risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

A. Risk Assessment

A medical, nutritional and psychosocial assessment is completed by the physician or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
2. Nutritional assessment to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status

Maximum: 2 units per pregnancy

B. Case Management Services

Services by a physician, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid gain access to needed medical, social, educational and other services (examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver the newborn, follow-up to verify the patient kept an appointment, rescheduling appointments). Services may be provided for low-risk or high-risk cases as determined by the risk assessment.

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (Physician, Public Health Nurse, Nutritionist, or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration, to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the physician or registered nurse employee may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the physician may request an early discharge home visit from any clinic which provides perinatal services. Visits will be done by physician order (including hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is a specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 292.676** of this manual.

250.200 Physician Assessment in the Hospital Emergency Department 2-1-22

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid has a physician assessment fee. (See **Section 292.682** for procedure code and billing instructions.) The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a primary care physician. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

251.220 Elective Abortions 2-1-22

Only medically necessary abortions are covered by Arkansas Medicaid. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest, defined under Ark. § Code Ann. 5-14-103 and § 5-22-202, as certified in writing by the woman's attending physician.

A. All abortions require prior authorization. A Certification Statement for Abortion (DMS-2698) must be completed prior to performing the procedure and is required for requesting prior authorization and billing. **View or print form DMS-2698**.

B. Other required documentation includes patient history and physical exam records. The physician performing the abortion is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. Refer to Section 292.410 for other billing instructions.

C. For abortions when the life of the mother would be endangered if the fetus were carried to term, prior authorization (PA) requests must be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting a review.**

D. Abortions for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services Utilization Review Section**. View or print the Utilization Review contact information.** Refer to Section 261.260 for instructions on requesting PA.

E. Payable Abortion Procedure Codes

1. For Professional or Outpatient Abortion Claims, the following codes are required:

   View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

2. For inpatient hospital facility Abortion Claims, the provider must use the following codes:

   a. 10A00ZZ – Abortion of Products of Conception, Open Approach
   b. 10A03ZZ – Abortion of Products of Conception, Percutaneous Approach
   c. 10A07Z6 – Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
   d. 10A07ZW – Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
   e. 10A07ZX – Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
   f. 10A07ZZ – Abortion of Products of Conception, Via Natural or Artificial Opening

251.230 Cochlear Implant and External Sound Processor Coverage Policy 2-1-22

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. (See Section 261.120 for prior authorization requirements and Section 292.801 for billing protocol.)

A. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Program for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) Program when prescribed by a physician.

The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or a switch from a body worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware, are considered not medically necessary and will not be approved.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*Denotes paper claim required

B. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

C. Personal FM Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems **(procedure code for use with cochlear implant)** that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

D. Replacement, Repair, Supplies

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

254.000 Enterra Therapy for Treatment of Gastroparesis 2-1-22

A. Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages eighteen (18) through sixty-nine (69) with diabetic and idiopathic gastroparesis (View ICD Codes.).

1. Service includes the implantable neurostimulator electrode(s) and the neurostimulator pulse generator.
2. Implantation procedures for neurostimulator pulse generator and the neurostimulator electrodes are covered as inpatient surgical procedures.
   a. The surgical procedures require prior authorization (PA) by DHS or its designated vendor.

      View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.
   b. An approval letter from the Institutional Review Board is required. Patient's record must include documentation that further total parental nutrition (TPN) therapy is not an option.
3. Procedure for revision or removal of the peripheral neurostimulator electrodes does not require PA, but claim will be manually reviewed prior to reimbursement.

C. See **Section 292.880** of this manual for procedure codes and billing instructions.

256.000 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

A. Arkansas Medicaid covers wireless endoscopy capsule for diagnosis of occult gastrointestinal bleeding in the anemic patient under the conditions listed below.

1. The site of the bleeding has not been identified by previous gastrointestinal endoscopy, colonoscopy, push endoscopy or other radiological procedures.
2. An abnormal x-ray of the small intestine is documented without an identified site of bleeding by endoscopic means.
3. Diagnosis of angiodysplasias of the GI tract is suspected, or
4. Individuals with confirmed Crohn's disease to determine whether there is involvement of the small bowel.

B. This procedure is covered for individuals of all ages based on medical necessity when performed with FDA-approved devices and by providers formally trained in upper and lower endoscopies.

C. Documentation of medical necessity requires a primary detail diagnosis of one of the following ICD diagnosis codes (**View ICD Codes**.).

D. GI tract capsule endoscopy is not covered in the patient who has not undergone upper GI endoscopy and colonoscopy during the same period of illness in which a source of bleeding is not revealed.

E. This test is covered only for those beneficiaries with documented continuing blood loss and anemia secondary to bleeding.

F. See **Section 292.890** for procedure code and billing instructions.

257.000 Tobacco Cessation Products and Counseling Services 2-1-22

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Physician providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial prior authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the patient. The prescriber must retain the counseling checklist in the patient records for audit. **View or Print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the twelve (12) visits per state fiscal year (SFY), but they are limited to no more than two (2) 15-minute units and two (2) 30-minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or EPSDT. These sessions do not require a PCP referral.

E. If beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling sessions limit described in section C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to **Section 292.900** for procedure codes and billing instructions.

261.120 Prior Authorization of Cochlear Implant, External Sound Processor and Repair/Replacement Supplies 2-1-22

A. Arkansas Medicaid provides coverage for cochlear implantation and for the external sound processor for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Prior authorization by AFMC is required.

B. A written request signed by the physician performing the procedure is required. The request must be accompanied by medical documentation to support medical necessity. See Section 261.100 for prior authorization instructions.

C. Prior Authorization for Repair and/or Replacement of Cochlear Implant External Components and Supplies

A request for prior authorization of a medically necessary FM system (for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to the Arkansas Foundation for Medical Care (AFMC) using **DMS-679-A**. **(View or print form DMS-679-A**.) All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization.

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record. See Section 261.100 of this manual for prior authorization procedures. Refer to Section 292.801 for further billing instructions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

261.250 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 2-1-22

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

261.260 Prior Authorization of Elective Abortion of Pregnancy Resulting from Rape or Incest 2-1-22

The following procedures must be followed to obtain prior authorization for elective abortion when pregnancy is the result of rape or incest:

A. The woman's physician must complete the Certification Statement for Abortion, form DMS-2698 (Rev. 8/04) certifying that the pregnancy resulted from forcibly compelled sexual intercourse or incest as defined under Ark. § Code Ann. 5-14-103 and § 5-22-202. **View or print form DMS-2698**.

1. The completed form DMS-2698 must include the name and address of the patient and be dated before the date of surgery.
2. The patient may sign the Certification Statement for Abortion (form DMS-2698) for herself at eighteen (18) years of age or older.
3. If the patient is under 18 years of age, then a parent or guardian must sign the Certification Statement for Abortion (form DMS-2698). The guardian must furnish a copy of the order appointing him or her guardian, or furnish the letters of guardianship issued by the court clerk.

B. Effective for dates of service on and after August 1, 2004, the physician must fax a completed form DMS-2698, patient history and medical exam records to the Department of Human Services (DHS), Division of Medical Services (DMS), Administrator, Utilization Review Section, for prior authorization of the abortion procedure. **View or print the Division of Medical Services Utilization Review contact information**.

C. DMS Utilization Review Section will convey its decision to the physician within 24 hours; or, if necessary, will request more information for the DMS physician's review. A DMS physician's review is required when UR reviewers deny authorization or need a physician's expertise.

D. The provider must submit the claim and required documentation for payment to the Department of Human Services, Division of Medical Services, Attention: Administrator, Utilization Review. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. **View or print the Division of Medical Services Utilization Review contact information.**

If the patient needs the Certification Statement for Abortion form (DMS-2698) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**

Refer to **Section 292.410** for special billing instructions and procedure codes.

262.000 Procedures That Require Prior Authorization 2-1-22

A. The following procedure codes require prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 261.100 of this manual for prior authorization instructions.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

** Denotes that AFMC Prior Authorization is required if these procedure codes are used to save the life of the mother and a Utilization Review Prior Authorization is required in cases for rape or incest. Refer to Sections 251.220, 261.200 and 261.260 for additional information.

B. The following 2013 CPT® Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for additional billing information.

C. The following 2012 Molecular Pathology CPT® procedure codes require a prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for billing additional information.

D. The following procedure codes require prior authorization by the Arkansas Division of Medical Services Utilization Review. (See Section 261.200 for instructions regarding prior authorization with the Division of Medical Services. See Section 292.950 for additional billing information and coverage criteria.)

263.000 Prescription Drug Prior Authorization 2-1-22

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a provider with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Refer to the **DHS contracted Pharmacy vendor's website** for the following information:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be completed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

E. Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

To access prior approval of these HCPCS procedure codes when necessary, reference the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor's website**.

292.410 Abortion Procedure Codes 2-1-22

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from DHS or its designated vendor.

Abortion for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services, Administrator, and Utilization Review.

The physician must request prior authorization for the abortion procedures and for anesthesia. Refer to Section 260.000 of this manual for prior authorization procedures. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes.

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical are required for processing of claims.

Use the following procedure codes when billing for abortions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Refer to Section 251.220 of this manual for policies and procedures regarding coverage of abortions and Sections 261.000, 261.100, 261.200, 261.260 for prior authorization instructions.

292.420 Allergy and Clinical Immunology 2-1-22

Allergy testing is available for all eligible Medicaid beneficiaries regardless of age, but allergy immunotherapy is payable only for eligible children under the Child Health Services (EPSDT) Program.

When charges for children under the Child Health Services (EPSDT) Program are billed to the Medicaid Program for the above services, the health care provider should check "Yes" in the child screening referral section of the claim, Field 24H, on the CMS-1500 claim form only if the service is a direct referral resulting from a Child Health Services (EPSDT) screen (examination). **View a CMS-1500 sample form.**

Appropriate CPT procedure codes should be used when billing for procedures listed in the allergy and clinical immunology section of the CPT book.

Reimbursement of allergy testing will be paid on a "per test" basis. Enter the exact number of tests performed in the "Units" field. Procedure codes must be billed.

Procedure code is not a payable code.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

All laboratory tests done in conjunction with allergy testing or immunotherapy must also be billed by the provider who actually performs the test. Refer to Section 292.600 of this manual for information on specimen collection.

292.430 Ambulatory Infusion Device 2-1-22

Procedure code, modifier **RR**, **Ambulatory Infusion Device**, is payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

One unit of service equals one day. A reimbursement rate has been established and represents a daily rental amount. See Section 261.210 of this manual for Prior Authorization information.

292.440 Anesthesia Services 2-1-22

Anesthesia procedure codes (**00100** through **01999**) must be billed in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate, anesthesia procedure codes that have a base of four (4) or fewer are eligible to be billed with a second modifier, **"22,"** referencing surgical field avoidance.

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

For electronic claims for Anesthesia services (procedure codes 00100 through 01999), total minutes should be billed in the units field.

B. Paper Claims

If paper billing is required, enter the procedure code, time, and units as shown in Section 292.447. Enter again the number of units (each fifteen (15) minutes of anesthesia equals one (1) time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

C. The following CPT procedure codes require attachments or documentation.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*****Other documentation may be requested upon review.**

D. Anesthesiologist/anesthetists may bill procedure code for any inpatient or outpatient dental surgery using place of service code "**11**," "**21**," "**22**", or "**24**," as appropriate. This code does not require Prior Approval for anesthesia claims.

E. A maximum of seventeen (17) units of anesthesia are allowed for a vaginal delivery or Cesarean Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or Cesarean Section deliveries. Only one (1) anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.442 Epidural Therapy 2-1-22

Procedure code should be billed with one (1) unit of service at the time of insertion only. Providers are to bill for daily pain management utilizing procedure code, with one time unit of 15 minutes, with no additional payment to the anesthetist for hospital visits. In cases where the method of anesthesia for surgery is an epidural anesthetic, providers are not allowed to re-bill for the insertion of a catheter for pain management unless there is documentation attached to verify two separate insertions were done. CPT procedure codes describing catheter and/or reservoir/pump implantation are to be used for long-term therapy.

Procedure code must be billed when performed by an anesthesiologist/CRNA.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.443 Medicaid Coverage for Therapeutic Infusions (Excludes Chemotherapy) 2-1-22

Effective for dates of service on and after March 1, 2006, procedure codes are non-payable. These codes have been replaced with procedure codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.446 Time Units 2-1-22

Time units will be added to the Base Value and the Anesthesia Modifier for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision. Enter the time units in Field 24G for paper claims. If filing electronically, the value submitted in this field should be the total anesthesia in minutes.

Anesthesia stand-by should be billed as detention time using procedure code**.** One unit equals 30 minutes. A maximum of one unit per date of service may be billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.470 Fluoride Varnish Treatment 2-1-22

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus (1) day for beneficiaries under age twenty-one (21).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20). **View a CMS-1500 sample form.**

292.480 Cataract Surgery 2-1-22

Post-cataract lens implant must be billed using procedure code. This procedure code may be billed electronically or on paper. The lens implant code is billed in conjunction with the cataract surgery and is covered for eligible Medicaid beneficiaries of all ages in the outpatient setting.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.490 Clinical Brachytherapy 2-1-22

The following is clarification regarding Medicaid's policy for hospital admissions, daily visits and discharges in conjunction with clinical brachytherapy. CPT currently states, "Services **77750** through **77799** include admission to the hospital and daily visits." The Medicaid Program does not cover separate payment for hospital admissions or inpatient physician visits when procedure codes are billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.510 Dialysis 2-1-22

A. Hemodialysis

The following procedure codes must be used by the nephrologist when billing for acute hemodialysis on hospitalized patients. Class I and Class II must have a secondary diagnosis listed to justify the level of care billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

These are global codes. Hospital visits are included and must not be billed separately.

B. Peritoneal Dialysis

The following procedure codes must be used when billing for physician inpatient management of peritoneal dialysis. Class I and Class II must have a secondary diagnosis code listed to justify the level of care billed.

These are global codes. Hospital visits are included and must not be billed separately.

C. Outpatient Management of Dialysis

The Arkansas Medicaid Program will reimburse for outpatient management of dialysis under procedure codes.

One day of dialysis management equals one unit of service. A provider may bill one day of outpatient management for each day of the month unless the beneficiary is hospitalized. When billing for an entire month of management, be sure to include the dates of management in the "Date of Service" column. Only one month of management must be reflected per claim line with a maximum of 31 units per month. If a patient is hospitalized, these days must not be included in the monthly charge. These days must be split billed. An example is:

Arkansas Medicaid also covers Iron Dextran for beneficiaries of all ages who receive dialysis due to acute renal failure. Use procedure code when administering in a physician's office.

Procedure codes are payable for eligible Medicaid beneficiaries of all ages who receive dialysis due to acute renal failure (**View ICD Codes.**).

292.521 Consultations 2-1-22

When billing for office consultations when the place of service is the provider's office (POS: **11**) or inpatient hospital (POS: **21**), use the appropriate CPT procedure codes according to the description of each level of service.

The consultation procedure codes listed below must be used when the place of service is outpatient hospital or emergency room-hospital (POS: **22** or **23**, respectively) or ambulatory surgical center (POS **24**).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Medicaid does not cover follow-up consultations. A consulting physician assuming care of a patient is providing a primary evaluation and management service and bills Medicaid accordingly within CPT standards.

For information on benefit limits for all consultation (inpatient and outpatient) refer to Section 226.100 of this manual.

292.523 Detention Time 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code must be used by physicians when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a physician.

292.525 Hospital Discharge Day Management 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code**,** hospital discharge day management, may not be billed by providers in conjunction with an initial or subsequent hospital care code, procedures**.** Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

292.530 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.) 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Payment for E.S.W.L. is available through the Medicaid Program for the “physician operator” and the “aftercare physician.” The physician operating the lithotripter must use CPT procedure code. If a bilateral procedure is done, enter a “2” in the units column. The physician who did not perform the surgery but who referred the patient to the facility for the lithotripsy procedure and will provide “aftercare” services, should bill for the actual services rendered. The anesthesiologist should follow normal billing procedures. Refer to Sections 251.260 and 272.400 of this manual for coverage and reimbursement information.

292.540 Factor VIII, Factor IX and Cryoprecipitate 2-1-22

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician’s office or in the patient’s home. The following procedure codes must be used:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Factor VIII [antihemophilic factor (human)], per IU

Factor VIII [antihemophilic factor (porcine)], per IU

Factor VIII [antihemophilic factor (recombinant)], per IU

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code must be used when billing for Factor IX Complex (human). Factor IX Complex (Human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

The Arkansas Medicaid Program covers procedure code Cryoprecipitate. This procedure is covered when provided to eligible Medicaid beneficiaries of all ages in the physician's office, outpatient hospital setting or patient's home.

Providers must attach a copy of the manufacturer's invoice to the claim form when billing for Cryoprecipitate.

For the purposes of Factor VIII, Factor IX and Cryoprecipitate coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

292.551 Family Planning Services For Beneficiaries 2-1-22

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail**. **Please note: See the tables below within this section to determine restrictions applicable to some procedures**. Laboratory procedure codes covered for family planning are listed in **Section 292.552**.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

F. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 292.552**.

292.552 Family Planning Laboratory Procedure Codes 2-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and the limited coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning, as listed in Section A below. Laboratory codes payable to hospital-based physicians are listed in Section 292.552 (C) below.

A. The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*Procedure codes are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

¤See points B and C below for information regarding this procedure code.

¤¤When **not** billing for family planning, see Section 292.602.

B. Laboratory codes payable to **non-hospital-based** physicians

The following procedure code table explains laboratory services payable to non-hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to **hospital-based** physicians

The following procedure code table describes the laboratory services payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

292.560 Genetic Services 2-1-22

The Arkansas Medicaid Program covers the following procedure codes regarding genetic services.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Documentation

In addition to the medical records physicians are required to keep as detailed in Section 202.200 of this manual, the beneficiary's medical record must verify the physician providing genetic services is a board-certified maternal fetal medicine physician as required by Arkansas Medicaid genetic policy.

B. Prenatal Diagnosis Counseling

Prenatal Diagnosis Counseling must be performed by a maternal fetal medicine physician or a staff member under his or her direct supervision. This service includes, but is not limited to:

1. Family, medical, pregnancy history
2. Psychosocial assessment and counseling of couple regarding genetic testing and disorder
3. Diagnosis, prognosis, available options, pregnancy management are explained to the couple.

C. Services Not Performed by a Physician

When procedure code **(must be billed on paper)** is provided and the services are not performed by a physician, the provider must have written policies with a physician who assumes the responsibility for the provision of the services rendered and agrees:

1. To be immediately available for consultation to the staff performing the services,
2. To ensure that the clinic staff has appropriate training and adequate skills for performing the procedures for which they are responsible and
3. To periodically review the staff's level of performance in administering these procedures.

The physician must be physically present (under the same roof) at all times during the service delivery.

292.561 Hysteroscopy for Foreign Body Removal 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code requires paper billing and clinical documentation for justification.

292.580 Hysterectomies 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Physicians may use nationally recognized procedure code when billing for a total hysterectomy procedure when the diagnosis is malignant neoplasm or severe dysplasia. See Section 251.280 for additional coverage requirement.

Procedure code does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1500. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

292.591 Molecular Pathology 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code requires prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the 365-day filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.**

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory services (**Form DMS-841**) and all pertinent clinical documentation needed to justify the procedure. Reconsideration of a denied request is allowed if new or additional information is received within thirty (30) days of the initial denial. A copy of the **DMS-841** is located in Section V of this provider manual. **View or print form DMS-841**. Do not complete DMS-841 unless you are submitting a Molecular Pathology Prior Authorization request. **Molecular Pathology procedure codes must be submitted on a red line CMS-1500 claim form with the Prior Authorization number listed on the claim form and the itemized invoice attached which supports the charges for the test billed.**

Use Healthcare Common Procedural Coding System Level II (HCPCS) procedure code for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for must be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841). Prior authorization for must be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for must include the CPT Molecular Pathology procedure code for which the Interpretation and Report is to be provided. must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology code(s) specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number. The invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

See Section 262.000 for additional information on Molecular Pathology procedure codes.

292.600 Laboratory and X-Ray Services 2-1-22

Only laboratory and X-ray services carried out in the physician's office or under his/her direct supervision may be billed by the physician to the Medicaid Program. Laboratory and X-ray services ordered by the physician but carried out in an outside facility must be billed directly to Medicaid by the outside facility. Physician will be reimbursed for collection fee only.

Medicaid regulations regarding collection, handling and/or conveyance of specimens are:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

292.602 Special Billing Requirements for Lab and X-Ray Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.603 Billing Protocol for Computed Tomographic Colonography (CT) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography codes are covered with a primary ICD diagnosis of (**View ICD codes.)**
2. CT colonography is billable electronically or on paper claims.

See Section 225.200 for coverage protocol

292.620 Office Medical Supplies - Beneficiaries Under Age 21 2-1-22

For beneficiaries under age 21, procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Procedure code is limited to beneficiaries under age 21. Use the EP modifier for ARKids A.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.650 NeuroCybernetic Prosthesis 2-1-22

Arkansas Medicaid requires prior authorization for the following procedures related to the implantation, revision and removal of the NeuroCybernetic Prosthesis (NCP®), a vagus nerve stimulator (VNS):

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.660 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician can refer interested individuals to the Department of Human Services through the Hospital/Physician Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

Newborn Care Services (Initial Screening)

These procedure codes represent the initial newborn screening. This screening includes the physical exam of the baby and the conference(s) with newborn's parent(s) and is considered to be the initial newborn care/screen. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Note the descriptions, modifiers and required diagnosis range. For all providers, the newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis of (View ICD Codes.).

A. Physician Billing Instructions for Newborn Care

For ARKids First-A (EPSDT): Requires a CMS-1500 claim form; may be billed electronically or on paper.

See Sections 241.000 – 242.400 of the EPSDT manual for specific EPSDT billing instructions.

For ARKids First-B: Requires a CMS-1500 claim form; may be billed electronically or on paper.

View or print Child Health Services contact information.

For illness care, e.g., neonatal jaundice, use procedure codes. Do **not** bill in addition to these codes.

When billing for critical care services, refer to the CPT book for procedure codes and billing information.

For newborn resuscitation, use procedure code.

292.671 Method 1 - "Global" or "All-Inclusive" Rate 2-1-22

The global method of billing should be used when one (1) or more physicians in a group see the patient for a prenatal visit and one (1) of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the beneficiary's physician visit benefit limit if the global method is billed.

A. One (1) charge for total obstetrical care is billed. The single charge includes the following:

1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to the pregnancy.
2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.
3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.
4. Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

B. The global method must be used when the following conditions exist:

1. At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.
2. The patient was continuously Medicaid eligible for two (2) months or more months before delivery and on the delivery date.

If either of the two (2) conditions is not met, the services will be denied, stating either "monthly billing required" or "beneficiary ineligible for service dates".

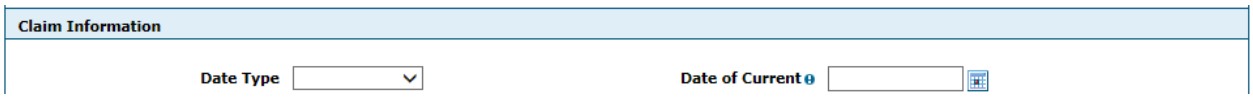
C. The correct codes for billing Medicaid for global obstetric care are as follows.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim. The delivery date is the date that is to be in the From and To Date of Service billed on the line with the above codes. The first date of antepartum care is to be billed in the "Initial Treatment Date" field.

For the CMS 1500 claim form, this is field 15 – Other Date Field. Qualifier 454 is required.

For the Provider Portal, the Date Type is "Initial Treatment Date" and the Date of Current is the first date of antepartum care.



If these two (2) dates are not entered and are not at least two (2) months apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.

292.672 Method 2 - "Itemized Billing" 2-1-22

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided

B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. Date-of-service spans shall not include any dates for which the patient was ineligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

If Method 2 is used to bill for OB services, providers must ensure that the services are billed within the 365-day filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes must be billed for vaginal delivery and procedure codes must be billed for cesarean section. Procedure codes shall not be billed in addition to procedure codes**.** These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician's standard office practice for billing OB patients. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are totally dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code consists of four components: Complete Blood Count, VDRL, Rubella and blood typing and RH. If the ASO titer is performed, the test must be billed separately using the individual code.

Only a collection may be filled for laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.673 Fetal Non-Stress Test and Ultrasound 2-1-22

The Arkansas Medicaid Program covers the fetal non-stress test and the ultrasound when performed in conjunction with maternity care.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Arkansas Medicaid imposes a benefit limit of two medically necessary fetal non-stress test procedures per pregnancy. Fetal ultrasound is limited to two per pregnancy. If it is necessary to exceed these limits, the physician must request benefit extensions, when applicable, in accordance with benefit extension request instructions in this provider manual.

292.674 External Fetal Monitoring 2-1-22

Procedure code must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code **"11.** Physicians may bill for one unit per day of external fetal monitoring. Physicians may bill for external fetal monitoring in addition to a global obstetric fee. When itemizing obstetric visits, physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.675 Obstetrical Care Without Delivery 2-1-22

A. Obstetrical care without delivery may be billed using procedure code, modifier **UA**, when 1 – 3 visits are provided and with no modifiers when 4 – 6 six visits are provided. Procedure code with no modifiers is payable for 7 or more visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

B. These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes are not counted against the patient's annual physician visit benefit limit. Reimbursement for each visit includes routine sugar and protein analysis. Other lab tests may be billed separately within 12 months of the date of service.

C. Providers must enter the dates of service in the CMS-1500 claim format and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

View a CMS-1500 sample form.

For example: An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. The Arkansas Medicaid fiscal agent must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: with modifier **UA** when 1 – 3 visits are provided, with no modifiers when 4 – 6 visits are provided and procedure code when 7 or more visits are provided.

292.676 Risk Management for Pregnancy 2-1-22

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

For early discharge home visits, use one of the applicable CPT procedure codes.

292.682 Non-Emergency Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code, modifier **U1**, should be billed for a non-emergency physician visit in the emergency department. Procedure code, modifier **U1**, requires PCP referral. This procedure code is subject to the non-emergency outpatient hospital benefit limit of 12 visits per state fiscal year (SFY).

Physicians must use procedure code, modifier **U2**, **Physician Outpatient Clinic Services** for outpatient hospital visits. This service requires a PCP referral. Procedure codes, modifier **U1**, and, modifier **U2**, are subject to the benefit limit of 12 visits per SFY for non-emergency professional visits to an outpatient hospital for patients age 21 and over.

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid established a physician assessment fee. Procedure code, **Physician Assessment in Outpatient Hospital** is payable for beneficiaries enrolled with a PCP. The procedure code does not require PCP referral. The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a PCP. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

292.684 Outpatient Hospital Surgical Procedures 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The CPT surgical codes for the covered procedure should be used for billing. Reimbursement for the procedure will be based on the Medicaid Physician Fee Schedule. When billing a miscellaneous surgical code, attach an operative report.

292.690 Pelvic Examinations, Prostatic Massages, Removal of Sutures, Etc. 2-1-22

These services are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.730 Professional and Technical Components 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Covered laboratory and radiology procedure codes in code range as well as covered services listed in the Medicine section of CPT and HCPCS procedure codes manuals that require the use of a machine may be billed electronically or on paper. Codes in this range without an applicable modifier signify a complete procedure.

Applicable modifiers are required in Field 24D in addition to the procedure code. Modifier **TC** must be used for the technical component and modifier **26** must be used for the professional component.

292.742 Family/Group Psychotherapy 2-1-22

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code is payable only when the patient is present during the treatment. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

292.760 Rural Health Clinic (RHC) Non-Core Services 2-1-22

Physician groups whose individual practitioners are contracting with a rural health clinic are limited to billing Medicaid for Rural Health Clinic (RHC) non-core services. These providers may bill the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

RHC NON-CORE SERVICES	
Outpatient Hospital Visits	**Inpatient Hospital Visits**
Non-emergency: modifier U1	
Emergency:	
Electrocardiograms and Echocardiography Technical component only Modifier TC	**Radiology Technical component only Modifier TC**
Surgery, Outpatient and Inpatient	
All payable CPT procedure codes within range	

NOTE: Inpatient and outpatient hospital services are RHC non-core services only if the physician's contract with the RHC does not state that the physician will be compensated by the RHC for those services. Interpretation of X-rays and diagnostic machine tests in the inpatient or outpatient hospital is a non-core service when the visit itself is a non-core service. Home visits, nursing facility visits or other off-site visits are RHC encounters if the physician's agreement with the RHC requires that he or she provide the services and seek compensation from the RHC. Any of these off-site services is payable separately (through the Physician Program) from the RHC encounter fee if it is not a part of the physician's contract with the RHC.

See Sections 201.120 and 246.000 of this manual for additional information.

292.770 Sexual Abuse Examination for Beneficiaries 0 - 20 Years 2-1-22

The procedure code **for Sexual Abuse Examination** listed in the table below is payable to physicians when provided in the physician's office or in a hospital outpatient department, emergency or non-emergency, with National Place of Service: **code "11", "23" or "22"**. This procedure is exempt from the PCP referral requirement and is covered for beneficiaries 0 - 20 years.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.790 Surgical Procedures with Certain Diagnosis Ranges 2-1-22

The following procedure codes are payable by the Arkansas Medicaid Program only if the diagnosis is in the range listed below:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.801 Cochlear Implant and External Sound Processor Billing Protocol 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code - Cochlear device implantation, with or without mastoidectomy - may be billed only by the physician performing the surgical procedure. When the cochlear device is provided by the physician, the physician may bill procedure code for the cochlear device using **EP** modifier. Paper claims require a modifier **EP** for the device. Procedure code require prior authorization. The physician must attach a copy of the invoice to the CMS-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill for the device. Refer to Section 251.230 of this manual for coverage information.

Procedures are covered for beneficiaries under age 21 and must be billed with modifier **EP**.

The following procedure codes must be prior authorized. (See Section 261.120 for Prior Authorization requirements and Section 251.230 for coverage policy). Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

Some cochlear implant parts have previously been covered services under an unlisted procedure code.

The table below contains new and existing HCPCS procedure codes of FM system for use with a cochlear implant and replacement cochlear implant parts.

Please note: Coverage and billing requirements to the physician provider for cochlear device implantation is unchanged. (See Section 251.230 for coverage requirements.)

Billing and Reimbursement Protocol for FM system and replacement cochlear implant parts:

Procedure codes will be billable electronically or on paper. Claims with procedures codes requiring paper billing must be submitted with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. May be submitted electronically or on a paper claim form. Provider charges for an FM system that is meant to be used with a cochlear implant should reflect the retail price. Reimbursement of an FM system to be used with a cochlear implant will be at 68 percent of the retail price.

* Indicates requirement of paper billing with manufacturer invoice attached.

292.821 Billing for Corneal Transplants 2-1-22

The following CPT procedure codes are payable for corneal transplants with prior approval:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Medicaid will reimburse the physician for the acquisition and preservation of the cornea. Medicaid will not reimburse for the transportation of the cornea. HCPCS procedure code must

be used when billing for the acquisition and preservation of the cornea. This code must be billed in conjunction with the transplant surgery. An itemized statement for the acquisition and preservation of the cornea must accompany the CMS-1500 claim form. **View a CMS-1500 sample form.**

292.822 Billing for Renal (Kidney) Transplants 2-1-22

A. The following CPT procedure codes are payable for renal transplants with prior approval:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is non-payable.

1. A separate claim must be filed for the donor. If the donor is not Medicaid eligible, the claim should be filed under the Medicaid beneficiary's name and Medicaid ID number. Diagnosis code (**View ICD Codes.**) (Donors, kidney) must be used for the renal donor and diagnosis code (**View ICD Codes.**) (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.
2. If the donor is a Medicaid beneficiary, the claim must be filed utilizing the donor's Medicaid ID number. However, the diagnosis codes listed above must be used.

B. HCPCS procedure code, modifier **UA**, must be used by providers billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code, modifier **UA**, on the claim in conjunction with the transplant surgery. An itemized statement for the transportation and preservation of the kidney must accompany form CMS-1500. **View a CMS-1500 sample form.**

292.823 Billing for Pancreas/Kidney Transplants - Under Age 21 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The appropriate CPT procedure code should be used when billing for pancreas/kidney transplantation for individuals under age 21 in the Child Health Services (EPSDT) Program. These procedure codes include. Procedure codes for allograft preparation are.

Pancreas/kidney transplantation procedure codes require prior approval. The appropriate code(s) may be billed in conjunction when performing the pancreas/kidney transplant procedure. This surgery will be treated as a multiple surgery and will be reimbursed accordingly.

292.824 Billing for Bone Marrow Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. CPT procedure codes are payable, with prior approval, for a bone marrow transplant. See Section 261.220 of this manual for prior approval information.

B. Harvesting procedure codes do not require prior approval and must be used when billing for the donor.

C. All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

D. CPT procedure code requires an ICD diagnosis code of (**View ICD Codes.**).

1. No claims will be considered for payment after the 60 calendar days have elapsed.

2. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

292.825 Billing for Heart Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is payable for a heart transplant. This code requires prior approval.

292.826 Billing for Liver Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is payable for a liver transplant. This code requires prior approval.

292.827 Billing for Liver/Bowel Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Liver/bowel transplant procedure codes require prior approval.

B. Procedure code is to be used for the liver.

C. Procedure codes are to be used for the intestine, as applicable.

292.828 Billing for Lung Transplants 2-1-22

Arkansas Medicaid covers lung transplants (single or double) for beneficiaries of all ages, if deemed medically necessary and prior approved. Use the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.831 Billing for Tissue Typing 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

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

B. The tissue typing is subject to the $500 annual lab and X-ray benefit limit.

1. Extensions will be considered for individuals who exceed the $500.00 annual lab and X-ray benefit limit.
2. Providers must request an extension.

C. Medicaid will authorize up to 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.

292.840 Vascular Embolization and Occlusion 2-1-22

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.850 Blood or Blood Components for Transfusions 2-1-22

The Arkansas Medicaid Program will reimburse for blood or blood components used for transfusions in the physician's office. CPT procedure code should be used for the administration fee. This includes all supplies used to perform the transfusion. The blood or blood components supplied by the physician may be billed using CPT procedure code.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A copy of the invoice must be attached to the claim form with the amount that was charged for the blood product circled. The number of units provided to the Medicaid eligible patient must be indicated on the invoice. Any laboratory procedures performed may be billed using the appropriate CPT procedure codes.

292.860 Hyperbaric Oxygen Therapy (HBOT) Procedures 2-1-22

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy (HBOT). Physicians billing for the physician component of "Physician attendance and supervision of hyperbaric oxygen therapy" **may bill for only one unit of service per day.** The physician's charge for each service date must include all his or her hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Physicians may bill for surgery and professional components of anatomical lab procedures, X-rays and machine tests in addition to.

B. Physicians may file paper or electronic claims for with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

NOTE: Refer to Section 258.000 of this manual for coverage policy, diagnosis requirements and treatment schedules.

292.880 Enterra Therapy for Gastroparesis 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

When filing claims for Enterra therapy for treatment of gastroparesis, use procedure code for implantation of gastric electrical stimulation and for implantation of peripheral neurostimulator electrodes. A prior authorization number is required on the claim.

Procedure code must be used when filing claims for revision or removal of the peripheral neurostimulator. This procedure does not require prior authorization but the claim must be filed on paper with operative report attached.

292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as, is payable for all ages and must be billed with the primary detail diagnosis of (**View ICD Codes.**).

This procedure code should be billed with no modifiers when performed in the physician's office place of service.

Modifier 26 must additionally be used to indicate billing for the professional component when performed in the inpatient, outpatient hospital, or ambulatory surgical center place of service.

CPT code is payable on electronic and paper claims. For coverage policy, see Section 256.000.

292.900 Tobacco Cessation Counseling Services 2-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

* Exempt from PCP referral.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count toward the four (4) counseling session limit described in section C above.

G. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**

Oral surgeons must use procedure code for one 15-minute unit and procedure code for one 30-minute unit when filing claims on the American Dental Association (ADA).

See Section 257.000 of this manual for coverage and benefit limit information.

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder 2-1-22

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate

   a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group who has at least one (1) performing provider with an X-DEA number on file with Arkansas Medicaid.

i. For new patients, the provider group shall use HCPCS code, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

iii. For established patients requiring maintenance follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

iv. The specific HCPCS code and modifiers found in the following link are required for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services**.

2. Method 2 – Regular Fee-for-Service Rates

a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

ii. For established patients requiring continuing treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

iii. For established patients requiring maintenance treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: (**View ICD OUD Codes.**)

Allowable lab and screening codes may be found here: (**View Lab and Screening Codes**.)

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

292.940 Radiopharmaceutical Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Prior Approval is required before services associated with the use of procedure codes may be provided. To obtain a Prior Approval Letter from the Division of Medical Services Medical Director for Clinical Affairs, the provider must furnish the following documentation (See Section 244.100 and 292.595.):

1. The FDA approved diagnosis clearly stated
2. Treatment failures that the patient has previously experienced
3 The patient's history and physical report

Prior Approval is required before services associated with the use of procedure code may be provided. To obtain Prior Approval, the provider must submit the following documentation:

1. The patient's history and physical
2. A report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic

Prior Approval is required for the service associated with the use of procedure code. To obtain Prior Approval, the provider must submit:

1. A history and physical
2. A report on what other profusion scans have been tried and are non-diagnostic

Some HCPCS laboratory and radiology services are payable only with diagnosis restrictions. For payment, these diagnoses must be entered on the claim.

*List 003 diagnosis codes include (**View ICD Codes.**). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Radiopharmaceutical therapy is covered with prior approval from the Medical Director for Clinical Affairs of the Division of Medical Services. Claims must be filed using procedure code.

1. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.
2. A copy of the Medical Director for Clinical Affair's approval letter and a copy of the invoice for the monoclonal antibody used must be attached to the claim form.

Refer to Section 244.200 for coverage information and instructions for requesting prior approval.

For coverage information regarding any drug not listed in Section 292.950, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

292.950 Injections, Therapeutic and/or Diagnostic Agents 2-1-22

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

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

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

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

Cannot be billed when the drug administered is not FDA approved.

See the table below when billing:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

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

See Section 292.940 for coverage information of radiopharmaceutical procedure codes.

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

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

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

See Section 292.940 for radiopharmaceutical drugs.

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

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

C. **Immunizations**

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

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

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

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

D. **Vaccines for Children (VFC)**

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

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information**.

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables section of this manual. See Part F of this section.

E. **Billing of Multi-Use and Single-Use Vials**

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

1. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.
2. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
    a. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
    b. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
    c. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
    d. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e. for manual review), complete every field of the **DMS-664** “Procedure Code/NDC

Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

See Section 292.910 for additional information regarding National Drug Code (NDC) billing.

F. **Tables of Payable Procedure Codes**

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

1. The **first** column of the list contains the CPT or HCPCS procedure codes.
2. The **second** column indicates any modifiers that must be used in conjunction with the procedure code when billed, either electronically or on paper.
3. The **third** column indicates that the coverage of the procedure code is restricted based on the beneficiary's age in number of years(y) or months (m).
4. The **fourth** column indicates specific ICD primary diagnosis restrictions.
5. The **fifth** column contains information about the "diagnosis list" for which a procedure code may be used. See the page header for the diagnosis list 003 detail.
6. The **sixth** column indicates whether a procedure is subject to medical review before payment.
7. The **seventh** column indicates a procedure code requires a prior authorization before the service is provided. (See Section 261.100 for Prior Authorization instructions.)

G. Process for Obtaining a Prior Authorization Number from Arkansas Foundation for Medical Care (AFMC)

In collaboration with AFMC, DMS has changed the process for acquiring prior approval for drug procedure codes from a prior approval letter to a Prior Authorization number (PA). Instead of attaching a prior approval letter to a paper claim, providers will now list the Prior Authorization number on the claim. Drug procedure codes requiring Prior Authorization should be billed with the PA number listed on the claim form. These drugs may be billed electronically or on a paper claim.

As part of the transition, AFMC will send a letter to all providers who have approval letters spanning timeframes within the last 365 days at the time of the effective date of this policy. The letter will contain a Prior Authorization number and the total remaining number of the approved units that can be billed. Any providers who have questions regarding Prior Authorization numbers and/or the transition process outlined above can contact AFMC at the following:

Toll Free: 1-877-350-2362, ext. 8741 or (501) 212-8741

A Prior Authorization number (PA) must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a Prior Authorization is required in a provider manual or an official Division of Medical Services correspondence.

The Prior Authorization requests should be completed using the approved AFMC Prior Authorization request form and must be submitted by mail, fax or **https://afmc.org.reviewpoint/ (View or print PA form.)**

A decision letter will be returned to the provider by fax or *e* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary.

Denials will be subject to reconsideration if received by AFMC with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

H. Contact Information for Obtaining Prior Authorization

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

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

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(501) 212-8663
Web portal	**https://afmc.org.reviewpoint/**
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 003/103 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 003/103 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

TOC not required

212.000 Scope 2-1-22

A. The Arkansas Medicaid Program covers podiatrist services through 42 Code of Federal Regulations, Section 440.60.

B. Arkansas Medicaid covers podiatrist services for eligible Medicaid beneficiaries of all ages.

C. Podiatrist services require a primary care physician (PCP) referral.

D. Podiatrist services include, but are not limited to, office and outpatient services, home visits, office and inpatient consultations, laboratory and X-ray services, physical therapy and surgical services. **Section 242.100** contains the full list of procedure codes applicable to podiatry services.

E. Many podiatrist services covered by the Arkansas Medicaid Program are restricted or limited.

1. Section 214.000 describes the benefit limits on the quantity of covered services clients may receive.

2. Section 220.000 describes prior-authorization requirements for certain services.

220.000 PRIOR AUTHORIZATION

There are certain surgical procedures and medical services and procedures that are not reimbursable without prior authorization, either because of federal requirements or because of the nature of the service.

DHS or its designated vendor performs prior authorizations for several medical or surgical procedures. Certain procedures are restricted to the outpatient setting unless prior authorized for inpatient services. Other services may only be billed when performed in a nursing home or skilled nursing facility setting. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

Section 242.120 contains the list of all procedure codes that require prior authorization.

242.100 Procedure Codes 2-1-22

Sections 242.100 through 242.120 list the procedure codes payable to podiatrists. Any special billing or other requirements are described in parts A through F of this section and in Sections 242.110 and 242.120.

View or print the procedure codes for Podiatrist services.

A. Procedure codes for podiatry services provided in a nursing home or skilled nursing facility are listed in Section 242.110.

B. Procedure codes for podiatry services require prior authorization. To request prior authorization, providers must contact the Arkansas Foundation for Medical Care, Inc. (AFMC) (see Section 221.000 – 221.100).

C. Procedure codes payable to podiatrists for laboratory and X-ray services are located in Section 242.130.

D. Procedure code, Hospital Discharge Day Management, may not be billed by providers in conjunction with an initial or subsequent hospital care code (procedure codes). Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

E. In addition to the CPT codes shown below are HCPCS codes and are payable to podiatrists. HCPCS code requires a paper claim. HCPCS codes must be billed with the manufacturer's invoice.

F. Procedure code must be billed for a service provided in a beneficiary's home.

The listed procedure codes and their descriptions are located in the *Physician's Current Procedural Terminology (CPT)* book. Section III of the Podiatrist Manual contains information on how to purchase a copy of the CPT publication.

*Procedure codes are manually priced and require an operative report attached to a paper claim.

**Procedure codes require prior authorization. See Section 221.000 for detailed instructions.

242.110 Procedure Codes Payable in a Nursing Care Facility 2-1-22

The following procedure codes may be billed when these services are provided in a nursing care facility.

View or print the procedure codes for Podiatrist services.

242.120 Procedure Codes Requiring Prior Authorization 2-1-22

The following procedure codes require prior authorization before services may be provided.

View or print the procedure codes for Podiatrist services.

242.130 Procedure Codes Payable for Laboratory and X-Ray Services 2-1-22

The following procedure codes may be billed for laboratory and X-ray services. Section 214.300 contains information regarding the $500.00 benefit limit for laboratory and X-ray services established for individuals age 21 and over.

View or print the procedure codes for Podiatrist services.

242.310 Completion of CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).

Field Name and Number			Instructions for Completion
		CITY	Name of the city in which the beneficiary or participant resides.
		STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
		ZIP CODE	Five-digit zip code; nine digits for post office box.
		TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.		PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.		INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
		CITY	
		STATE	
		ZIP CODE	
		TELEPHONE (Include Area Code)	
8.		RESERVED	Reserved for NUCC use.
9.		OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	RESERVED	Reserved for NUCC use.
		SEX	Not required.
	c.	RESERVED	Reserved for NUCC use.
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.		IS PATIENT'S CONDITION RELATED TO:	
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.

Field Name and Number	Instructions for Completion
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Podiatrist Services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use “9” for ICD-9-CM. Use “0” for ICD-10-CM. Enter indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The “from” and “to” dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections **242.100** through 242.130.
MODIFIER	Not applicable to Podiatrist Services claims.

Field Name and Number		Instructions for Completion
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

242.100 CPT Procedure Codes 2-1-22

The following CPT procedure codes are applicable to portable X-ray services:

Chest films not involving the use of contrast media:

Abdominal films not involving the use of contrast media:

Skeletal films involving arms and legs, pelvis, vertebral column and skull:

View or print the procedure codes for Portable X-ray services.

242.110 Transportation of Portable X-Ray Services 2-1-22

View or print the procedure codes for Portable X-ray services.

Procedure code represents the mileage and setup. If more than one Medicaid patient is seen at a place of service, the Medicaid maximum must be divided by the number of Medicaid patients seen.

242.310 Completion of CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.

Field Name and Number		Instructions for Completion
7.	INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.

Field Name and Number	Instructions for Completion
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: lLLNESS (First symptom) OR lNJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation. 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Not applicable to portable X-ray.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	

Field Name and Number			Instructions for Completion
		CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.110.
		MODIFIER	Modifier(s) if applicable.
	E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
	F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
	G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
	H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
	I.	ID QUAL	Not required.
	J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
		NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER		Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.		Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?		Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE		Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID		Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30.	RESERVED		Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

212.203 Cochlear Implants for Beneficiaries Under Age 21 2-1-22

Cochlear implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of 21 years through the Child Health Services (EPSDT) program when prescribed by a physician.

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components, or a switch from a body-worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware are not considered medically necessary and will not be approved.

A. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processors will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

B. Personal FM (Frequency Modulation) Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available from any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A request for prior authorization may be submitted for medically necessary FM systems (procedure code for use with cochlear implant) that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

C. Replacement, Repair, Supplies

The repair or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics Programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

D. Prior Authorization

A request for prior authorization of a medically necessary FM system (for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to the Arkansas Foundation for Medical Care (AFMC) using form **DMS-679A**. All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization. **View or print form DMS-679A and instructions for completion.**

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for, and payment of, services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record.

The following procedure codes must be prior authorized. Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

The table below contains new and existing HCPCS procedure codes for FM systems for use with cochlear implant and replacement cochlear implant parts.

NOTE: Coverage and billing requirements for the physician provider for cochlear device implantation are unchanged.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

*Denotes paper claim

See Section 242.155 for information on billing and reimbursement for FM system and replacement cochlear implant parts.

212.210 DME Low-Profile Percutaneous Cecostomy Tube (Low-Profile Button) for Beneficiaries of All Ages 2-1-22

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes. **(View ICD codes.)**

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

232.000 Specialized Wheelchair, Seating and Rehabilitative Equipment Reimbursement for Repairs 2-1-22

Reimbursement for **repairs** of specialized wheelchairs will be the manufacturer's list price for parts listed less 40% manual equipment (dealer discount), 30% power equipment (dealer discount), plus 35% (profit margin), plus labor billed by the unit (15 min. = 1 unit). A maximum of twenty (20) units (20 units = 5 hours of labor) per date of service is allowable. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to the claim form.

Reimbursement for specialized wheelchair equipment, seating and rehab items requiring manual pricing is calculated using the manufacturer's current published suggested retail price less 15%. Any applicable pages from the manufacturer's catalog that reflect a description and the manufacturer's current published suggested retail price must be attached to the claim.

Kaye Products will be reimbursed at a set rate; therefore, the Kaye Products (procedure codes, modifiers **EP**, **U1**;, modifiers **EP**, **U3**; and, modifiers **EP**, **U4**) may be billed electronically.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

233.000 Orthotic and Prosthetic Reimbursement for Repairs 2-1-22

Providers must bill for the repair of orthotic appliances and prosthetic devices utilizing the procedure codes listed in the table below. One unit of service equals 15 minutes. A maximum of 20 units of service is allowed per date of service. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to all repair claims.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Reimbursement for orthotic appliances and prosthetic devices requiring **manual pricing** will be calculated using the manufacturer's invoice price plus 10%. The manufacturer invoice must be attached to all repair claims.

236.000 Reimbursement for Repair of the Enteral Nutrition Pump 2-1-22

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request**. Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* (**View or print form DMS-679A and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code after receiving prior authorization for the new piece of equipment.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.110 Respiratory and Diabetic Equipment, All Ages 2-1-22

When billed either electronically or on paper, procedure codes found in this section must be billed with certain modifiers. Modifiers in the section are indicated by the headings M1 and M2. When only the **NU** modifier is shown in the M1 column, the procedure code may be billed for beneficiaries of all ages. When **NU** and **EP** are listed together in the M1 column, the NU modifier must be used when billing for beneficiaries age 21 and over, and the EP modifier must be used when billing for beneficiaries under age 21. When a modifier is listed in the M2 heading, that modifier must be used in conjunction with either **NU** or **EP**.

Prior authorization requirements are shown under the heading PA. If prior authorization is needed, the information is indicated with a "Y" in the column; if not, an "N" is shown.

- ♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.
- ⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.111 Initial Rental of a DME Item for Individuals of All Ages 2-1-22

Procedure codes found in this section may be billed either electronically or on paper.

Some procedure codes have been assigned a modifier that affects the billing process. Required modifiers are indicated in the M1 column in the list below. When a modifier is shown in the M1 column, it must be listed along with the procedure code when requesting payment by Arkansas Medicaid.

Procedure codes shown in the list below are either covered for all ages (AA), only for individuals under age 21 (U21) or only for individuals age 21 and over (21+). A column in the list below defines the differences.

- ♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.
- ⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Providers will be reimbursed for a minimum of 30 days of rental when the equipment is used less than 30 days. Initial rental codes must be billed when equipment is used less than 30 days during the first month of rental.

Arkansas Medicaid will only reimburse for one initial minimum 30 days of rental per state fiscal year period per beneficiary per procedure code. The provider will not be reimbursed for the same procedure code utilizing another modifier for the same time period.

242.112 Home Blood Glucose Monitor and Supplies – Pregnant Women Only, All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **NU** for individuals of all ages. When a second modifier is listed, that modifier must be used in conjunction with the **NU** modifier.

Modifiers in the section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.120 Medical Supplies for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper using modifier **NU** for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the modifier **NU**.

Modifiers in this section are indicated by the headings M1 and M2

- 1 Not all medical supplies require prior authorization. Supplies with this symbol require prior authorization. Form DMS-679A must be used to request prior authorization. Note:

Compression burn garments are manually priced. The manufacturer's invoice must be submitted with the request for compression burn garments. **View or print form DMS-679A and instructions for completion.**

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.121 Food Thickeners, All Ages 2-1-22

Food thickeners, including "Thick-It," "Thick-It II," "Simply Thick," "Thick and Easy" and "Thick and Clear" are not subject to the $250 medical supply benefit limit.

The modifier **NU** must be used with the procedure code found in this section and when food thickeners are to be administered enterally, the modifier "**BA**" must be used in conjunction with the procedure code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may not be rounded up. When a date span is billed, the product cannot be billed until the end date has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.122 Jobst Stocking for Beneficiaries of All Ages 2-1-22

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by DHS or its designated vendor. **View or print contact information for how to submit the request.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose veins with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy. **View or print form DMS-679A and instructions for completion.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.123 Negative Pressure Wound Therapy Pump Accessories and Supplies for Beneficiaries Ages 2 Years and Older 2-1-22

Effective for dates of service on or after May 11, 2012, procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries aged 2-20 years or modifier **NU** for beneficiaries aged 21 and over.

Modifiers in this section are indicated by the heading M1. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.130 Diapers and Underpads for Beneficiaries Ages 3 Years and Older 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Reimbursement is based on a per unit basis with one unit equaling one item (diaper, underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Providers should not bill "from" and "through" dates of service.

Refer to Section 212.100 of this manual for coverage information on diapers and underpads.

242.140 Electronic Blood Pressure Monitor and Cuff, All Ages 2-1-22

The procedure code found in this section must be billed either electronically or on paper using modifier **NU** for individuals of all ages.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

♦Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Included with the rental of this monitor, the provider will need to supply one (1) disposable blood pressure cuff each month.

242.150 Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age 2-1-22

The following list provides the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

The coverage listed is payable only if the service is prescribed as a result of a Child Health Services (EPSDT) screening/referral.

No prior authorization is required for nutritional formulae for EPSDT beneficiaries from age five (5) years through twenty (20) years.

Prior authorization is required for beneficiaries from birth through four (4) years. Use of modifier **U7** in the following list will be necessary, as indicated.

To request prior authorization, providers should complete the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (DMS-679A), attaching a copy of the EPSDT screening/referral as well as a prescription signed by the beneficiary's PCP. **View or print form DMS-679A**. **View or print contact information for how to submit the request.**

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC Program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preferences for formulae will not be considered for medical necessity.

Exceptions to Use of Formulae

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk or soy protein; chronic diarrhea, short gut; cystic fibrosis; fat malabsorption due to GI or liver disease.

D. Gerber Extensive HA – Allergy to milk or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome; known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen, or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24– Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. Modifier **BO** is used to bill for oral usage. When a second or third modifier is listed, that modifier must be used in conjunction with **EP**.

For beneficiaries from birth through four (4) years of age, the use of modifier **U7,** as well as additional documentation will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

Modifiers in this section are indicated by the headings M1, M2, M3 and M4.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

One (1) unit of service equals one-hundred (100) calories with a reimbursable maximum of thirty (30) units per day. Supplies furnished by prosthetics providers in conjunction with the nutritional formula must be billed to Medicaid with the prosthetics medical supply codes. These formulae are covered as nutritional supplements rather than as the sole source of nutrition.

NOTE: Beneficiaries who require enteral nutrition as the sole source of nutrition with the formulae being administered through a nasogastric, jejunostomy or gastrostomy tube should be referred to a hyperalimentation provider enrolled in the Medicaid Program.

Each claim should reflect a “from” and “through” date of service. The claims must not be filed until after the “through” date has elapsed. Claims may be submitted on either a weekly or a monthly basis.

242.151 Pedia-Pop 2-1-22

The procedure code found in this section must be billed with modifier **EP**. Pedia-Pop is only for oral consumption, and is only in frozen form.

Modifiers in this section are indicated by the headings M1 and M2.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. When a second modifier is listed, that modifier must be used in conjunction with **EP**.

The procedure codes require prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services. **Enteral Nutrition Infusion Pump**

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid.

Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan.

Codes are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day.

Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for codes. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See Section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

242.153 Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and Low-Profile Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages 2-1-22

NOTE: When billing for the Low-Profile Percutaneous Cecostomy Tube or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and service.

242.154 Nasogastric Tubing for Individuals Under Age 21 2-1-22

The procedure code found in this section must be billed with modifier **EP** for beneficiaries under 21 years of age. The code is payable only for beneficiaries under age 21.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.155 Billing and Reimbursement Protocol for FM (Frequency Modulation) System and Replacement Cochlear Implant Parts 2-1-22

Procedure codes in the table below require paper claim submission with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. Procedure codes may be submitted electronically or on a paper claim form. Procedure code may be submitted

electronically or on a paper claim form. For provider charges for an FM system that is meant to be used with a cochlear implant, should reflect the retail price. For reimbursement of an FM system to be used with a cochlear implant, will be at 68 percent of the retail price.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

*Denotes paper claim

242.160 Durable Medical Equipment, All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**. Modifier **UE** is required when billing for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

*	The purchase of wheelchairs for individuals age 21 and older is limited to one per five-year period.
***	This procedure code may not be billed for used equipment.
♦	Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.
⁂(…)	This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.
3	This item is a capped rental for 90 days only, and requires PA and a review.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Procedure codes must be billed when hospital beds are purchased for Medicaid beneficiaries of all ages. Providers must only provide these purchase-only services to beneficiaries who are expected to require the bed for a long period of time. **Each procedure code for hospital beds listed above may only be billed once every 10 years.**

Procedure codes must also be used to bill for equipment that does not meet the purchase-only criteria. They are reimbursed on a capped rental basis. The capped rental items must be used until the equipment is no longer repairable or until it is no longer appropriate for the beneficiary as verified by the physician.

242.170 Apnea Monitors for Beneficiaries Under 1 Year of Age 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age. Modifier **UE** must be used to bill for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Sections 212.300 and 222.200 contain information regarding specific coverage and restrictions.

♦	Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.180 Orthotic Appliances for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for individuals age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown. When prior authorization is not applicable (for U21) that information is shown with an "N/A" in the column.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for individuals under age 21 and "21+" is shown when the code is payable only for those individuals age 21 and older.

** This item is not a covered service for the diagnosis of Carpal Tunnel Syndrome prior to surgery.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

■ This procedure code does not require prior authorization; however, the beneficiary's medical condition must fall within the following diagnosis codes. **(View ICD codes.)**

+ This item is limited to one every twelve months for beneficiaries age 21 and over.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.190 Prosthetic Devices for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for beneficiaries age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for beneficiaries under age 21 and "21+" is shown when the code is payable only for those beneficiaries age 21 and older.

1 The purchase of this component is limited to one per five-year period for beneficiaries age 21 and over.

* Replacement only

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

NOTE: Procedure codes for prosthetic eyes and information regarding prosthetic eye care is located in the Arkansas Medicaid Visual Care Program Manual.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.191 Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult 2-1-22

Arkansas Medicaid covers wheelchairs and wheelchair seating systems for individuals ages two through adult.

For any item to be covered by Arkansas Medicaid, the beneficiary must be eligible for a defined Medicaid Aid Category. Coverage is subject to the requirement that the equipment must be medically necessary for the diagnosis or treatment of an illness or injury to improve the functioning of an affected body part, and must meet all other Medicaid statutory and regulatory requirements and established criteria.

The beneficiary's diagnosis must warrant the type of equipment being purchased. Items may not be covered in every instance.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and the provider at the time service is provided and submission of an accurate and complete request. The DME provider is responsible for verifying the eligibility of the beneficiary at the time service is provided.

Specialized wheelchairs and wheelchair seating systems must be ordered by a physician.

For those services that are not included in the Arkansas Medicaid State Plan, (e.g., highly technological wheelchairs and rehab equipment), the PCP must complete form DMS-693, titled Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan. **View or print form DMS-679 and instructions for completion.**

NOTE: If the service or item(s) are specifically included in the Arkansas Medicaid State Plan, the completion of form DMS-693 is not required.

When a request is submitted for a power wheelchair, Power-Operated Vehicle (POV) or specialized manual wheelchair, the following Medicaid requirements must be met:

A. A Prescription & Prior Authorization Request for Medical Equipment form (DMS-679) must be completed and submitted. This form must not be altered by the provider. **View or print form DMS-679 and instructions for completion.**

B. The DMS-679 must be signed and dated by the beneficiary's PCP, APRN or the ordering physician. The signature must be original. Stamp signatures are not acceptable. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

C. Correct Medicaid procedure codes and modifiers must be utilized. Requested items will be denied if correct procedures codes and modifiers are not used.

D. All requests for prior authorization must be legible (felt pens must not be used).

E. Medicaid requires the submission of the original request.

F. Medical documentation from the beneficiary's PCP, APRN or ordering physician which included a detailed face-to-face medical examination must be submitted to establish medical necessity.

G. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. This evaluation will be completed in three parts:

1. Part A—to be completed by the DME provider.
2. Part B—to be completed by the assistive technology practitioner or can be completed by a physical therapist or occupational therapist or seating specialist for Group 1 (one) and Group 2 (two) power wheelchairs with no power options.
3. Part C—to be completed by the beneficiary's PCP, APRN or the ordering physician.
4. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be completed for all specialized wheelchairs except for rental wheelchairs. **View or print form DMS-0843 and instructions for completion.**

H. A manufacturer's order form documenting the suggested retail price for the brand and model wheelchair and accessories and a manufacturer's quote must be submitted with the DMS 679.

I. A DMS-693, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, must be submitted for all pediatric wheelchairs and include detailed PCP or APRN medical documentation that clearly demonstrates medical necessity and clearly identifies the medical condition and the specific equipment that will meet the beneficiary's medical needs. Form DMS-693 and the supporting documentation must be submitted as an attachment to the request for prior authorization. It will then be reviewed for medical necessity. **View or print form DMS-693.**

J. If requirements A through I are not completed correctly, the request could be denied.

K. Arkansas Medicaid requires a Durable Medical Equipment (DME) provider to employ a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified ATP (Assistive Technology Practitioner) who specializes in wheelchair seating. The ATP will provide direct in-person recommendations for evaluation of the beneficiary's wheelchair selection, and is employed by the supplier. This applies for specialized manual wheelchair and power wheelchair in the category of Group 2 (single power option) and above.

The ATP's involvement in the wheelchair selection must be documented. Documentation of the ATP's involvement does not qualify as a face-to-face examination and may not be cosigned by a physician.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Other coding information found in the chart:

[1] **The purchase of this component for beneficiaries age 21 and older is limited to one per five-year period.**

[2] **The purchase of this wheelchair component for beneficiaries under age 21 is limited to one per two-year period.**

* **The purchase of wheelchairs for beneficiaries age 21 and older is limited to one per five-year period.**

** **Bill only for beneficiaries under age 21.**

\# **This procedure code is payable for beneficiaries ages 2 through 20. Prior authorization is required through Utilization Review.**

**** **Items listed require prior authorization (PA) when used in combination with other items listed and the total combined value exceeds the $1,000.00 Medicaid maximum allowable reimbursement limit.**

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

Note: W/C or w/c indicates wheelchair.

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Required Documentation

Face-to-Face Examination

In order for Medicaid to provide reimbursement for a Power/motorized Wheelchair (PWC), Power Operated Vehicle (POV) (scooter) or specialized manual wheelchair, the following requirements must be met.

A. A face-to-face physician examination must be performed.

B. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.

C. The prescription must be written only **after** the face-to-face physician examination and assessment of mobility limitations have occurred and the medical history and physical examination is completed.

D. The prescription and the medical records documenting the in-person visit and examination report must be sent to the equipment supplier within forty-five (45) days of completion of the examination.

E. The physician may refer the beneficiary to a licensed/certified professional, a Physical Therapist (PT) or Occupational Therapist (OT) to perform a wheelchair assessment.

If the beneficiary is referred to a physical/occupational therapist before the physician completes the face-to-face examination, the physician must review the physical/occupational therapist's written report and perform the final examination. The forty-five (45)-day period begins on the date of the physician's final face-to-face examination and must be submitted with the prior authorization request.

The face-to-face examination must include:

A. History of the present condition(s) and past medical history that is relevant to mobility needs:

1. Symptoms that limit ambulation.
2. Diagnoses that are responsible for these symptoms.
3. Medications or other treatment for these symptoms.

4. Progression of ambulation difficulty over time.
5. Other diagnoses that may relate to ambulatory problems.
6. How far the patient can walk without stopping.
7. What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently being used.
8. What has changed to now require use of a power mobility device.
9. Ability to stand up from a seated position without assistance.

B. Physical examination that is relevant to mobility needs:

1. Beneficiary's weight and height.
2. Cardiopulmonary examination.
3. Musculoskeletal examination, arm and leg strength and range of motion.
4. Neurological examination, gait, balance and coordination.

The examination should be tailored to the individual patient's condition. The history should clearly establish the patient's functional abilities and limitations related to mobility and ambulation.

In addition to all other requirements, a power mobility device is covered by Medicaid **only** if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home.

Provider-created forms and letters are not a substitute for other required forms and will not be considered.

Additional Wheelchair Documentation

A. The purchase of a wheelchair for individuals twenty-one (21) years of age and over is limited to one wheelchair per five (5)-year period if medically necessary. A wheelchair is a dependable mobility base with positioning components. It has complex positioning capabilities and is designed to grow in width, depth and height to accommodate physical changes of its users, it is of use to people with certain medical conditions and serves a specific medical purpose related to the condition of the patient.

B. The purchase of a wheelchair for an individual twenty (20) years of age and under is limited to one per two (2)-year period, if medically necessary.

C. Payment is made for one wheelchair only as stipulated in A. and B. Backup and loaner D. wheelchairs are not covered by Arkansas Medicaid.

D. Requests for a wheelchair that is beneficial primarily in allowing the beneficiary to perform leisure or recreational activities only will be denied. It is not medical in nature. Wheelchairs are authorized for medical use only.

E. Strollers and stroller-like chairs of any kind are not covered by Arkansas Medicaid. A stroller is a four-wheeled, often collapsible, chair-like carriage. They are helpful to caregivers and are typically used for transportation. Although stroller and stroller-like chairs may be used to transport individuals with medical conditions, such items do not serve a medical purpose. Strollers and stroller-like chairs have no positioning components for medical use, cannot be modified for growth and accommodate changes in medical or physical condition, and cannot be self-propelled by the individual.

F. Prior authorization is required even when insurance pays primary to Medicaid. Explanation of benefits (EOB) of the other insurance must be submitted with the request.

G. All wheelchair requests require a manufacturer's brand and the model name of the base.

H. In the event a wheelchair is stolen, damaged in the home, or by vehicle or fire, a police/fire report, copy of the home owners/auto insurance coverage and detailed documentation of events leading to the loss/damage are required.

I. Mobility bases for car seats are not covered by Medicaid.

J. Options, accessories, and replacement parts that are medically necessary for wheelchairs that do not have specific HCPCS codes should be coded (other accessories). The manufacturer's suggested retail price (MSRP) must be listed for each item coded, and the MSRP quote to the DME provider must be included. The MSRP quote must not be altered by the DME provider. If the MSRP is altered in any way, the request will be denied.

K. In the event a beneficiary wishes to change services from one DME provider to another DME provider, an affidavit signed and dated by the beneficiary must be submitted with the request from the new DME provider.

L. The existence of a procedure code does not necessarily indicate coverage by Arkansas Medicaid.

M. The allowed amount of a POV includes all options and accessories that are provided at the time of initial issue. This includes but is not limited to batteries, battery chargers, seating systems, etc. All options and accessories provided at the initial issue of a Power-Operated Vehicle (POV) are included and should not be billed separately.

N. If coverage criteria is not met for a specific item requested, and Arkansas Medicaid determines that another item is more appropriate and meets medical necessity, that item will be authorized.

O. The wheelchair will significantly improve the beneficiary's ability to participate in Mobility Related Activities of Daily Living (MRADL) and the individual will use the wheelchair on a regular basis in the home.

P. The individual's home will provide adequate access between rooms, maneuvering space and surface for use of the requested wheelchair.

Non-Covered Items for Specialized Wheelchairs and Wheelchair Systems

A. Items that are deluxe in nature. Deluxe items are items of convenience that are not medically necessary. Deluxe items are often used for social purposes or convenience. Deluxe items include deluxe accessories which increase the cost of purchase or operation. Deluxe items and deluxe accessories are not covered by Arkansas Medicaid.

B. Items for use in hospitals, nursing home or other institutions.

C. Items for the beneficiary's comfort or the caregiver's convenience.

D. Two pieces of equipment that serve the same purpose.

E. Backup and loaner wheelchairs.

F. Wheelchairs that primarily allow the beneficiary to perform leisure or recreational activities.

G. Mobility bases for car seats.

H. Items that are not primarily used in the treatment of a disease, injury or illness.

I. Any items or item upgrades that add cost without improving the beneficiary's ability to perform Mobility Related Activities of Daily Living.

Warranty, Maintenance and Replacement of Specialized Wheelchairs and Wheelchair Systems

All standard durable medical equipment must have a manufacturer's warranty. If a DME provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, adjustments, replacements and maintenance. The warranty begins on the date of delivery (date of service) to the beneficiary. The DME provider must keep a copy of the warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

DME suppliers must furnish at least a minimum of six (6) months warranty for any adjustments to new wheelchairs at no charge.

Labor will not be covered for the initial chair and for parts and services that are under warranty.

242.192 Specialized Rehabilitative Equipment for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

** **Indicates that providers may bill only for beneficiaries under age 21.**

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.193 Speech Generating Device for Beneficiaries of All Ages 2-1-22

The speech generating device must be billed using the procedure code assigned to each component. The specific components will be reimbursed, as needed, for the procedure codes listed below and will count toward the lifetime limit of $7,500 per beneficiary.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

NOTE: Attach a manufacturer's invoice to the claim and indicate the item or parts billed on the invoice. A description and the amount billed for each item must be attached to the claim. If more than one item is billed under a procedure code, the description and billed amount of each item must be listed separately under each procedure code and attached to the claim. The total billed for each procedure code should be reflected in field 24F.

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Note: When repair charges for both parts and labor of the SGD is provided and/or billed on the same date of service, only one detail (parts only or labor only) of procedure code may be billed per beneficiary per date of service. Information must be specified on the paper claim to clarify the charges billed by the provider. Parts and labor charges must be itemized by narrative and documentation.

A. The charge for parts must be clearly documented. A manufacturer's invoice for the parts must be attached.

B. The labor charge and the time represented by the labor charge must be clearly documented.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems 2-1-22

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used. See **Section 242.191**.

E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**

F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.

G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.

H. Arkansas Medicaid will not cover repairs/damage due to the following:

1. Neglect.
2. Misuse.
3. Abuse.
4. Improper installation or repair by the DME provider.

5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.

I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.

J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

Miscellaneous

A. Only a physician can order a wheelchair.

B. A physician's evaluation is valid for a period of six (6) months. After six (6) months, the beneficiary must be re-evaluated by the physician to determine medical necessity for continued need based upon changes in conditions and measurements.

A DME request is considered outdated by Medicaid when it is first presented to Medicaid more than ninety (90) days from the date it was written, signed and dated by the physician.

242.402 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

TOC not required

242.100 Procedure Codes 2-1-22

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

HCPCS procedure code must be billed on a paper claim with the manufacturer's invoice attached.

242.121 CPT Procedure Codes: Therapy 2-1-22

The CPT procedure codes that are payable to a rehabilitative hospital are as follows:

View or print the procedure codes and modifiers for Rehabilitative Hospital services.

TOC not required

252.101 Billing Instructions for Family Planning Visits 2-1-22

Effective on and after April 30, 2010, all claims submitted from RHC providers for family planning visits are to use the following billing protocol, regardless of the date of service. No RHC family planning visits should be billed under the physician's provider number. The revised billing protocol will allow correct payment according to the benefit limit for eligible Arkansas Medicaid beneficiaries.

Rural Health Clinic providers are to bill revenue codes **0524** (for Independent RHCs) and **0525** (for Provider-Based RHCs), as well as an applicable procedure code and modifier. Procedure code with modifier **U9** will be used for the basic family planning visit, and with modifier **U9** will be used for the periodic family planning visit. This is shown in the following table. RHC basic and periodic family planning visits are billable electronically and on paper claim forms. All family planning services require a primary diagnosis of family planning on the claim.

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.102 Billing Instructions for EPSDT and ARKids First-B Medical Screenings 2-1-22

Effective on or after April 30, 2010, all claims submitted by RHC providers for EPSDT and ARKids First-B medical screens performed by RHC personnel are to use the following billing protocol, regardless of the date of service. No screens should be billed under the physician's provider number. **However, if the screens were billed earlier under the physician's provider number, do not re-bill.** RHC providers are to bill the appropriate screen codes and modifiers. Each RHC's individual encounter rate will now be reimbursed when the RHC bills one of these medical screen procedure codes with the correct modifier(s). However, the encounter rate will only be reimbursed if the charge for the service submitted on the claim is greater than or equal to the RHC's encounter rate. The RHC will be reimbursed the lesser of the billed amount or their encounter rate.

Example – If an RHC's encounter rate is $75 and the RHC submits a screen claim with a billed amount of $85, the RHC will be reimbursed the lesser $75 encounter rate. If the same RHC submits a screen claim with a billed amount of $70, the RHC will be reimbursed the $70 lesser amount and not the encounter rate. Screens are billable electronically and on paper claims.

For ARKids First-A (EPSDT) electronic billing, medical screens will require the electronic 837P with the special program indicator "01" in the header, along with the appropriate certification condition indicator and code. At the detail level, the procedure code will be billed with the EP modifier and the second modifier. For ARKids First-A (EPSDT) paper billing, providers will bill on the CMS-1500 claim form using the EP modifier and the second modifier. See the Physician provider manual for more information.

For ARKids First-B (ARKids First) electronic billing, medical screens will require the 837P without the special program indicator (professional electronic claim) with no modifier except for newborn care procedures, which require a UA modifier. For ARKids First-B (ARKids First) paper billing, providers will bill on the CMS-1500 claim form with no modifier except for newborn care procedure codes, which require a UA modifier. See the ARKids First provider manual for more information.

This billing protocol is shown in the following table.

View or print the procedure codes for Rural Health Clinic (RHC) services.

252.103 Billing of Multi-Use and Single-Use Vials 2-1-22

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as "take-home drugs." Refer to payable CPT code ranges.

View or print the procedure codes for Rural Health Clinic (RHC) services.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

252.401 Upper Respiratory Infection – Acute Pharyngitis 2-1-22

A Rural Health Center (RHC) must submit a claim that includes CPT code in the Upper Respiratory Infection (URI)-Acute Pharyngitis episode if a strep test is performed when prescribing an antibiotic for beneficiaries. This allows DMS to determine if the Principle Accountable Provider (PAP) met or exceeded the quality threshold in order to qualify for a full positive supplemental payment for the URI-Pharyngitis episode.

View or print the procedure codes for Rural Health Clinic (RHC) services.

TOC not required

272.110 Mental Health Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION	
View or print the procedure codes for SBMH services.	Psychiatric diagnostic evaluation (with no medical services)	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Mental Health Diagnosis is a clinical service for the purpose of determining the existence, type, nature and appropriate treatment of a mental illness or related disorder as described in the current allowable DSM. This service may include time spent for obtaining necessary information for diagnostic purposes. The psychodiagnostic process may include, but is not limited to, a psychosocial and medical history, diagnostic findings, and recommendations. This service must include a face-to-face component and will serve as the basis for documentation of modality and issues to be addressed (Plan of Care). Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Date of service • Start and stop times of the face-to-face encounter with the beneficiary and the interpretation time for diagnostic formulation • Place of service • Identifying information • Referral reason • Presenting problem(s), history of presenting problem(s) including duration, intensity and response(s) to prior treatment • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Current functioning plus strengths and needs in specified life domains • DSM diagnostic impressions to include all axes • Treatment recommendations • Goals and objectives to be placed in Plan of Care • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
This service may be billed for face-to-face contact as well as for time spent obtaining necessary information for diagnostic purposes; however, this time may NOT be used for development or submission of required paperwork processes (i.e. treatment plans, etc.).	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	**Outpatient Behavioral Health Services Providers cannot bill on same date of service** View or print the procedure codes for SBMH services.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	

Face-to-face	School-Based Mental Health
ALLOWABLE PERFORMING PROVIDER	**PLACE OF SERVICE**
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03

272.120 Psychological Evaluation 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, Rorschach®, WAIS®), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Psychological evaluation for personality assessment includes psychodiagnostic assessment of a beneficiary's emotional, personality, and psychopathology, e.g. MMPI, Rorschach®, and WAIS®. Psychological testing is billed per hour both face-time administering tests and time interpreting these tests and preparing the report. This service may reflect the mental abilities, aptitudes, interests, attitudes, motivation, emotional and personality characteristics of the beneficiary. Medical necessity for this service is met when: • the service is necessary to establish a differential diagnosis of behavioral or psychiatric conditions; • history and symptomatology are not readily attributable to a particular psychiatric diagnosis; or • questions to be answered by the evaluation could not be resolved by a psychiatric/diagnostic interview,	• Date of service • Start and stop times of actual encounter with beneficiary • Start and stop times of scoring, interpretation and report preparation • Place of service • Identifying information • Rationale for referral • Presenting problem(s) • Culturally- and age-appropriate psychosocial history and assessment • Mental status/clinical observations and impressions • Psychological tests used, results, and interpretations, as indicated • DSM diagnostic impressions to include all axes • Treatment recommendations and findings

observation in therapy or an assessment for level of care at a mental health facility.	related to rationale for service and guided by test results • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
	60 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 8
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Psychological Examiner (LPE) • Psychologist	03	

272.130 Interpretation of Diagnosis 2-1-22

CPT®/HCPCS PROCEDURE CODE	**PROCEDURE CODE DESCRIPTION**	
View or print the procedure codes for SBMH services.	Interpretation or explanation of results of psychiatric or other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**	
Interpretation of Diagnosis is a direct service provided for the purpose of interpreting the results of psychiatric or other medical exams, procedures or accumulated data. Services may include diagnostic activities and/or advising the beneficiary and his/ her family. Consent forms may be required for family or significant other involvement. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence.	• Start and stop times of face to face encounter with beneficiary and/or parents or guardian • Date of service • Place of service • Participants present and relationship to beneficiary • Diagnosis • Rationale for and objective used that must coincide with the goals and objectives placed in Plan of Care • Participant(s) response and feedback • Staff signature/credentials/date of signature(s)	
NOTES	**UNIT**	**BENEFIT LIMITS**
For beneficiaries under the age of 18, the time may be spent face-to-face with the beneficiary, the	Encounter	DAILY MAXIMUM OF UNITS THAT MAY BE

beneficiary and the parent(s) or guardian(s) or alone with the parent(s) or guardian(s). For beneficiaries over the age of 18, the time may be spent face-to-face with the beneficiary and the spouse, legal guardian or significant other.		BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 1
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.140 Marital/Family Behavioral Health Counseling with Beneficiary Present 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Family psychotherapy with patient present (conjoint psychotherapy)
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**

<table>
<tr><td>Marital/Family Behavioral Health Counseling with Beneficiary Present is a face-to-face treatment provided to one or more family members in the presence of a beneficiary. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based, with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services are designed to enhance insight into family interactions, facilitate inter-family emotional or practical support and to develop alternative strategies to address familial issues, problems and needs. Services pertain to a beneficiary’s (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.</td><td colspan="2">• Date of Service
• Start and stop times of actual encounter with beneficiary and spouse/family
• Place of service
• Participants present and relationship to beneficiary
• Diagnosis and pertinent interval history
• Brief mental status of beneficiary and observations of beneficiary with spouse/family
• Rationale for, and description of treatment used, that must coincide with the master treatment plan and improve the impact the beneficiary's condition has on the spouse/family and/or improve marital/family interactions between the beneficiary and the spouse/family.
• Beneficiary and spouse/family's response to treatment that includes current progress or regression and prognosis
• Any changes indicated for the master treatment plan, diagnosis, or medication(s)
• Plan for next session, including any homework assignments and/or crisis plans
• Staff signature/credentials/date of signature
• HIPAA compliant release of Information, completed, signed and dated</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>Natural supports may be included in these sessions if justified in service documentation. Only one beneficiary per family per therapy session may be billed.</td><td>Encounter</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children and Youth</td><td colspan="2"></td></tr>
<tr><td>ALLOWED MODE(S) OF DELIVERY</td><td colspan="2">TIER</td></tr>
<tr><td>Face-to-face</td><td colspan="2">School-Based Mental Health</td></tr>
<tr><td>ALLOWABLE PERFORMING PROVIDERS</td><td colspan="2">PLACE OF SERVICE</td></tr>
<tr><td>• Licensed Certified Social Worker (LCSW)
• Licensed Master Social Worker (LMSW)
• Licensed Professional Counselor (LPC)
• Licensed Associate Counselor (LAC)
• Licensed School Psychology Specialist (LSPS)</td><td colspan="2">03</td></tr>
</table>

• Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	

272.150 Crisis Intervention 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	Crisis intervention service, per 15 minutes
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Crisis Intervention is unscheduled, immediate, short-term treatment activities provided to a Medicaid-eligible beneficiary who is experiencing a psychiatric or behavioral crisis. Services are to be congruent with the age, strengths, needed accommodation for any disability, and cultural framework of the beneficiary and his/her family. These services are designed to stabilize the person in crisis, prevent further deterioration and provide immediate indicated treatment in the least restrictive setting. (These activities include evaluating a Medicaid-eligible beneficiary to determine if the need for crisis services is present.)	• Date of service • Start and stop time of actual encounter with beneficiary and possible collateral contacts with caregivers or informed persons • Place of service • Specific persons providing pertinent information in relationship to beneficiary • Diagnosis and synopsis of events leading up to crisis situation • Brief mental status and observations • Utilization of previously established psychiatric advance directive or crisis plan as pertinent to current situation OR rationale for crisis intervention activities utilized • Beneficiary's response to the intervention that includes current progress or regression and prognosis • Clear resolution of the current crisis and/or plans for further services • Development of a clearly defined crisis plan or revision to existing plan • Staff signature/credentials/date of signature(s)

NOTES	UNIT	BENEFIT LIMITS
A psychiatric or behavioral crisis is defined as an acute situation in which an individual is experiencing a serious mental illness or emotional disturbance to the point that the beneficiary or others are at risk for imminent harm or in which to prevent significant deterioration of the beneficiary's functioning. This service can be provided to beneficiaries that have not been previously assessed or have not previously received behavioral health services. The provider of this service MUST complete a Mental Health Diagnosis (90791) within 7 days of	15 minutes	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 12 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 72

provision of this service. If the beneficiary needs more time to be stabilized, this must be noted in the beneficiary's medical record and the Division of Medical Services Quality Improvement Organization (QIO) must be notified.		
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth		
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.160 Individual Behavioral Health Counseling 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	psychotherapy, 30 min psychotherapy, 45 min psychotherapy, 60 min
SERVICE DESCRIPTION	**MINIMUM DOCUMENTATION REQUIREMENTS**
Individual Behavioral Health Counseling is a face-to-face treatment provided to an individual in an outpatient setting for the purpose of treatment and remediation of a condition as described in the current allowable DSM. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based with an emphasis on needs as identified by the beneficiary and provided with cultural competence. The treatment service must reduce or alleviate identified symptoms related to either (a) Mental Health or (b) Substance Abuse and maintain or improve level of functioning, and/or prevent deterioration. Additionally, tobacco cessation counseling is a component of this service.	• Date of service • Start and stop times of face-to-face encounter with beneficiary • Place of service • Diagnosis and pertinent interval history • Brief mental status and observations • Rationale and description of the treatment used that must coincide with objectives on the master treatment plan • Beneficiary's response to treatment that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis or medication(s)

	• Plan for next individual therapy session, including any homework assignments and/or advanced psychiatric directive • Staff signature/credentials/date of signature	
NOTES	**UNIT**	**BENEFIT LIMITS**
Services provided must be congruent with the objectives and interventions articulated on the most recent treatment plan. Services must be consistent with established behavioral healthcare standards. Individual psychotherapy is not permitted with beneficiaries who do not have the cognitive ability to benefit from the service.	30 minutes 45 minutes 60 minutes **View or print the procedure codes for SBMH services.**	DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1 YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested): 12 units
APPLICABLE POPULATIONS	**SPECIAL BILLING INSTRUCTIONS**	
Children and Youth	A provider may only bill one individual counseling/psychotherapy code per day per beneficiary. A provider cannot bill any other individual counseling/psychotherapy code on the same date of service for the same beneficiary.	
ALLOWED MODE(S) OF DELIVERY	**TIER**	
Face-to-face	School-Based Mental Health	
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE (POS)**	
• Licensed Certified Social Worker (LCSW) • Licensed Master Social Worker (LMSW) • Licensed Professional Counselor (LPC) • Licensed Associate Counselor (LAC) • Licensed School Psychology Specialist (LSPS) • Licensed Psychological Examiner (LPE) • Psychologist * School-Based Mental Health Services provider employees or contractors will provide services only in those areas in which they are licensed or credentialed.	03	

272.170 Group Outpatient – Group Therapy 2-1-22

CPT®/HCPCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
View or print the procedure codes for SBMH services.	A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and

<table>
<tr><td></td><td colspan="2">remediation of psychiatric condition.</td></tr>
<tr><td>SERVICE DESCRIPTION</td><td colspan="2">MINIMUM DOCUMENTATION REQUIREMENTS</td></tr>
<tr><td>Group Behavioral Health Counseling is a face-to-face treatment provided to a group of beneficiaries. Services leverage the emotional interactions of the group's members to assist in each beneficiary’s treatment process, support his/her rehabilitation effort, and to minimize relapse. Services must be congruent with the age and abilities of the beneficiary, client-centered and strength-based; with emphasis on needs as identified by the beneficiary and provided with cultural competence. Services pertain to a beneficiary’s (a) Mental Health and/or (b) Substance Abuse condition. Additionally, tobacco cessation counseling is a component of this service.</td><td colspan="2">• Date of Service
• Start and stop times of actual group encounter that includes identified beneficiary
• Place of service
• Number of participants
• Diagnosis
• Focus of group
• Brief mental status and observations
• Rationale for group counseling must coincide with master treatment plan
• Beneficiary's response to the group counseling that includes current progress or regression and prognosis
• Any changes indicated for the master treatment plan, diagnosis, or medication(s)
• Plan for next group session, including any homework assignments
• Staff signature/credentials/date of signature</td></tr>
<tr><td>NOTES</td><td>UNIT</td><td>BENEFIT LIMITS</td></tr>
<tr><td>This does NOT include psychosocial groups. Beneficiaries eligible for Group Outpatient – Group Psychotherapy must demonstrate the ability to benefit from experiences shared by others, the ability to participate in a group dynamic process while respecting the others' rights to confidentiality, and must be able to integrate feedback received from other group members. For groups of beneficiaries aged 18 and over, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 12. For groups of beneficiaries under 18 years of age, the minimum number that must be served in a specified group is 2. The maximum that may be served in a specified group is 10. A beneficiary must be 4 years of age to receive group therapy. Group treatment must be age and developmentally appropriate, (i.e., 16 year olds and 4 year olds must not be treated in the same group). Providers may bill for services only at times during which beneficiaries participate in group activities.</td><td>Encounter</td><td>DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 1

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED (extension of benefits can be requested):
Counseling Level Beneficiary: 12 units

Rehabilitative/Intensive Level Beneficiary: 104 units</td></tr>
<tr><td>APPLICABLE POPULATIONS</td><td colspan="2">SPECIAL BILLING INSTRUCTIONS</td></tr>
<tr><td>Children, Youth, and Adults</td><td colspan="2">A provider can only bill one Group Behavioral Health Counseling / Community Group Psychotherapy encounter per day. For</td></tr>
</table>

	Counseling Level Beneficiaries, there are 12 total group behavioral health counseling visits allowed per year unless an extension of benefits is allowed by the Quality Improvement Organization contracted with Arkansas Medicaid. For Rehabilitative/Intensive Level Beneficiaries, there are 104 total group behavioral health counseling visits allowed per year unless an extension of benefits is allow by the Quality Improvement Organization contracted with Arkansas Medicaid.
ALLOWED MODE(S) OF DELIVERY	**TIER**
Face-to-face	Counseling
ALLOWABLE PERFORMING PROVIDERS	**PLACE OF SERVICE**
• Independently Licensed Clinicians – Master's/Doctoral • Non-independently Licensed Clinicians – Master's/Doctoral • Advanced Practice Nurse • Physician	03, 11, 49, 50, 53, 57, 71, 72

TOC not required

215.000 Covered Air Ambulance Services 2-1-22

Please refer to Section 241.100 for reimbursement information. Please refer to **Section 252.100** for covered air ambulance services and the payable procedure codes.

241.100 Air Ambulance 2-1-22

Arkansas Medicaid reimburses turboprop, piston propelled and jet aircraft air ambulance services per hour of services (medical services) and per mileage (aircraft operating costs). The hourly rate will only be reimbursed for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing.

Arkansas Medicaid will reimburse ground transport salary and fringe expenses for the aircraft medical crew up to a maximum of $1,000 per total roundtrip flight for air nursing crew and air paramedic crew procedure codes. (See **Section 252.100** for procedure codes.) This reimbursement can only be made for medical crew assistance time while:

A. The crew travels to the hospital to pick up the patients;

B. The patient is being transported from the original hospital to the aircraft;

C. The patient is being transported from the aircraft to the receiving hospital and

D. The crew is traveling back to the aircraft after delivering the patient to the receiving hospital.

The ground transport medical crew time is reimbursable whether or not the crew actually accompanies the patient in the ground transport ambulance. The crew may travel in a separate vehicle, if necessary.

Arkansas Medicaid will reimburse air transport ventilator and respiratory therapist services. This service will only be reimbursed, when necessary, for patient care during transportation.

252.100 Ambulance Procedure Codes 2-1-22

The covered ambulance procedure codes are listed below.

View or print the procedure codes for Transportation (Ambulance) services.

Drug procedure codes require National Drug Codes (NDC) billing protocol. See Section 252.110 below.

*Procedure code can be billed only in conjunction with procedure code **(please keep all documentation supporting the medical necessity of all codes billed for retrospective review of claims).**

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

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas

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

2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** "Procedure Code/NDC Detail Attachment Form." Attach this form and any other required documents to your claim when submitting it for processing.

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

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

TOC not required

242.100 Ventilator Equipment and Supplies Procedure Codes 2-1-22

View or print the procedure codes for Ventilator services.

Procedure codes must be billed either electronically or on paper with the modifiers indicated.

Prior authorization requirements are shown under the heading PA.

[1]Code may only be billed for a ventilator patient in his or her home. The code is not covered for a ventilator patient in a nursing facility.

[2]Bill only for beneficiaries under age 21.

***Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

⁂(…)This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

242.310 Completion of CMS-1500 Claim Form 2-1-22

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.

Field Name and Number		Instructions for Completion
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
	a. INSURED'S DATE OF BIRTH	Not required.
	SEX	Not required.
	b. OTHER CLAIM ID NUMBER	Not required.

Field Name and Number	Instructions for Completion
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: lLLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary care physician (PCP) referral is not required for ventilator equipment services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.

Field Name and Number		Instructions for Completion
D.	PROCEDURES, SERVICES, OR SUPPLIES	
	CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from **Section 242.100**.
	MODIFIER	Modifier(s) if applicable.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G.	DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid co-payments.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required

214.200 Coverage and Limitations of the Under Age 21 Program 2-1-22

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve (12)-month benefit limit period, one additional pair will be available through the optical laboratory. After the first replacement pair, any additional pair will require prior authorization. There will be no co-payment assessed for replacement glasses requiring prior authorization.
3. All replacements will be made by the optical laboratory and the doctor's office may make repairs only when necessary.
4. EPSDT beneficiaries will have no co-pays. ARKids First-B beneficiaries will be assessed a $10.00 co-pay. All co-pays will be applied to examination codes rather than to tests or procedures.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to Section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses.

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

I. Prior authorized orthoptic and/or pleoptic training may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under.

1. The initial prior authorization request must include objective and subjective measurements and tests used to indicate diagnosis.

2. The initial prior authorization approved for this treatment will consist of sixteen (16) treatments in a twelve (12)-month period with no more than one treatment per seven (7) calendar days.
3. An extension of benefits may be requested for medical necessity.
4. Requests for extension of benefits must include the initial objective and subjective measures with diagnosis along with subjective and objective measures after the initial sixteen (16) treatments are completed to show progress and the need for, or benefit of, further treatment.
5. For a list of diagnoses that are covered for orthoptic and/or pleoptic training **(View ICD Codes.)**.

J. Prior authorized sensorimotor examination may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) sensorimotor examination in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for sensorimotor examination **(View ICD Codes.)**.

K. Prior authorized developmental testing may be performed only in the office of a licensed optometrist or ophthalmologist for Medicaid eligible children ages twenty (20) and under and for CHIP eligible children ages eighteen (18) and under who have received a covered diagnosis based on specific observed and documented symptoms.

1. Benefit limit of one (1) developmental testing in a twelve (12) month period.
2. An extension of benefits may be requested for medical necessity.
3. For a list of diagnoses that are covered for developmental testing **(View ICD Codes)**.

View or print the procedure codes for Vision services.

242.110 Visual Procedure Codes 2-1-22

The following services are covered under the Arkansas Medicaid Program. “W/PA” means that a service requires prior authorization.

View or print the procedure codes for Vision services.

DIAGNOSTIC AND ANCILLARY SERVICES
CONTACT LENS SERVICES
LOW VISION SERVICES
SUPPLEMENTAL PROCEDURES
MISCELLANEOUS SERVICES
CONTACT LENS REPLACEMENT
EYE PROSTHESIS

242.120 Co-pays for Prescription of Services 2-1-22

Co-pays apply to the following examination codes:

View or print the procedure codes for Vision services.

Co-pays do not apply to codes **f**or the fitting of spectacles,

243.120 CPT Codes Payable in the Visual Care Program 2-1-22

The following CPT codes are payable in the Visual Care Program. Optometrists may bill procedure code for treatment of dry eye syndrome.

View or print the procedure codes for Vision services.

*Procedure codes with one asterisk require prior authorization when the place of service is an inpatient hospital.
**Procedure code requires prior authorization and is limited to beneficiaries under age 21 years.
***Procedure code is manually priced and requires prior authorization.

Gross visual field testing is a part of general ophthalmologic services and is not billed separately. *See the CPT manual for definitions, examples of levels of service and complete procedure code descriptions.*

243.130 Hospital Discharge Day Management 2-1-22

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as initial or subsequent hospital care, procedure. Initial hospital care and subsequent hospital care may not be billed on the day of discharge.

View or print the procedure codes for Vision services.

243.140 Billing Instructions for Balanced Lens for Aphakia 2-1-22

Visual Care providers must bill procedure code (unspecified procedure) when providing balanced lenses to aphakia patients who are eligible for both Medicare and Medicaid. Medicaid providers must bill for this procedure using the CMS-1500 claim form. A copy of the lab invoice and the Medicare EOMB that reflects the denial must be attached to the claim.

View or print the procedure codes for Vision services.

243.150 Office Medical Services 2-1-22

The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Office medical services covered in the Visual Care Program are limited to the following procedure codes:

View or print the procedure codes for Vision services.

243.400 Special Billing Procedures 2-1-22

Prosthetic providers that bill procedure codes electronically must use an **NU** modifier. Prosthetic providers billing either of the above procedure codes on paper must also use an **NU** modifier.

View or print the procedure codes for Vision services.