ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Medical Services

Other Subdivision or Department, If Applicable N/A

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TOC not required

215.110 Benefit Limits for Diagnostic Laboratory and Radiology/Other Services

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

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

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

D. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

215.120 Benefit Extension Requests

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

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

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

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

MARK-UP

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

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

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

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

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

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

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

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

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

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

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

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

215.122 Documentation Requirements

~~7-1-22~~1-1-26

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

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1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

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

C. Clinical records must:

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

D. Laboratory and radiology/other reports must include:

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

MARK-UP

TOC not required

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

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

   View or print the essential health benefit procedure codes.

4. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

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

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

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

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

214.120 Documentation Requirements for Benefit Extension Requests

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

MARK-UP

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

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

C. Documentation requirements include the following:

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

MARK-UP

TOC not required

213.400 Diagnostic Laboratory and Radiology/Other Services

~~7-1-22~~1-1-26

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

A. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

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

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

View or print the essential health benefit procedure codes.

D. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

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

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

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

MARKUP

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

213.420 Diagnostic Laboratory and Radiology/Other Services Referral Requirements

~~7-1-22~~1-1-26

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

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

B. The following benefit limits apply:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY; and
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

214.100 Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

MARK-UP

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

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

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

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

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

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

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

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

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

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

MARK-UP

214.120 Documentation Requirements

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

C. Documentation requirements are as follows.

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

MARK-UP

TOC not required

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures

~~7-1-22~~1-1-26

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

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

   View or print the essential health benefit procedure codes.
5. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

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

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

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

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

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

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

MARKUP

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

H. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

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

215.100 Benefit Extension Requests

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

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

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

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

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

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

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

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

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

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

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

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

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

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

272.435 Tissue Typing

~~7-1-22~~1-1-26

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

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

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30);
2. Extensions will be considered for beneficiaries who exceed the five-hundred-dollar benefit limit for diagnostic laboratory services; and
3. Providers must request an extension.

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

MARK-UP

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

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

MARK-UP

TOC not required

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits ~~7-1-22~~1-1-26

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

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

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollar ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

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

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes**);
   b. HIV disease and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy* (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)
5. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

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

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

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

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

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

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

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

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.

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

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

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

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

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

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

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

MARK-UP

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

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

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

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

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

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

214.930 Documentation Requirements

~~7-1-22~~1-1-26

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

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

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

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

C. Documentation requirements are as follows.

1. Clinical records *must:*

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

   b. Be signed by the performing provider;

   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;

   d. Include related diabetic and blood pressure flow sheets;

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

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

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

MARK-UP

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

MARK-UP

TOC not required

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

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

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

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per SFY for radiology/other services, for ~~clients~~ beneficiaries twenty-one (21) years of age.

1. There are no laboratory or radiology/other benefit limits for ~~clients~~ beneficiaries under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. There is no benefit limit on professional components of laboratory or radiology/other services for hospital inpatient treatment.
3. There is no benefit limit on laboratory services related to family planning. See Section 292.552 for the family-planning-related clinical laboratory procedures exempt from the laboratory services benefit limit.
4. There is no benefit limit on laboratory services or radiology/other services performed as emergency services.
5. The benefit limit of $1,800 applies for laboratory services when the beneficiary is diagnosed with chronic pain and one or more of the **Chronic Pain Diagnosis Codes** are recorded on the claim, or the provider has requested prior authorization for laboratory services associated with pain management.

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

1. Claims with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (**View ICD Codes**);
   b. HIV infection and AIDS (**View ICD Codes**);
   c. Renal failure (**View ICD Codes**);
   d. Pregnancy (**View ICD Codes**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (**View ICD OUD Codes**). Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes**).

MARK-UP

2. Benefits may be extended for other conditions based on documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

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

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

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

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

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

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

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

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

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

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

MARK-UP

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

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

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

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

229.120 Documentation Requirements 7-1-22

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

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

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

C. Documentation requirements are as follows.

1. Clinical records *must*:

MARK-UP

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

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

292.831 Billing for Tissue Typing 7-1-22

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

B. The tissue typing is subject to the following benefit limit:
   1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500); or one thousand eight hundred dollars ($1,800) if the beneficiary is diagnosed with chronic pain or is being treated for pain management per State Fiscal Year (SFY: July 1 through June 30).
   2. Extensions will be considered for individuals who exceed the five-hundred-dollar ($500.00) benefit limit for diagnostic laboratory services.
   3. Providers must request an extension.

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

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

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

MARK-UP

3. Other Laboratory and X-Ray Services

Other professional and technical laboratory and radiological services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.

Diagnostic laboratory **s**ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY**,** July 1 – June 30~~),~~)unless the beneficiary is diagnosed with chronic pain or is being treated for pain management. Beneficiaries diagnosed with chronic pain or being treated for pain management are limited to one thousand eight hundred dollars ($1,800) per SFY for diagnostic laboratory services. ~~and~~ ~~r~~Radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for ~~recipients~~beneficiaries twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) or one thousand eight hundred ($1,800) per SFY diagnostic laboratory services benefit limit**,** and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do not apply to services provided to ~~recipients~~beneficiaries under twenty-one (21) years of age enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

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

(2) Services for pregnant women are specifically exempt from the per SFY diagnostic laboratory services benefit limit, and the per SFY radiology/other services health benefit limits. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the beneficiary's per SFY diagnostic laboratory services benefit limit or the per SFY radiology/other services health benefit limit.

~~(1)~~

~~(2)~~(3) Drug screening will be specifically exempt from the ~~five hundred dollars ($500)~~ per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD)**,** and the screening is part of a Medication Assisted Treatment **(**MAT**)** plan. The cost of these screenings will not be included in the calculation of the ~~recipient's~~beneficiary's ~~five hundred dollars ($500)~~ diagnostic laboratory services health benefit limit.

~~(3)~~(4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the ~~five hundred dollars ($500)~~ per SFY outpatient diagnostic laboratory services benefit limit ~~or~~ and the ~~five hundred dollars ($500)~~ per SFY radiology/other services health benefit limits. The cost of these procedures will not be included in the calculation of the ~~recipient's~~beneficiary's ~~five hundred dollars ($500)~~ per SFY diagnostic laboratory services benefit limit, or the ~~recipient's~~beneficiary's ~~five hundred dollars ($500)~~ per SFY radiology/other services health benefit limits.

~~(4)~~(5) Portable X-Ray Services are subject to the ~~five hundred dollars ($500)~~ per SFY radiology/other services benefit limit. Extensions of the benefit limit for ~~recipients~~beneficiaries twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible beneficiary~~recipient~~ in their place of residence upon the written order of the ~~recipient's~~beneficiary's physician. Portable X-ray **s**ervices are limited to the following:

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

MARKUP

~~(5)~~(6) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the ~~five hundred dollars ($500)~~ benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for ~~recipients~~beneficiaries twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

MARK-UP

3. Other Laboratory and X-Ray Services

Other professional and technical laboratory and radiological services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined under 42 CFR 440.30 in an office or similar facility other than a hospital outpatient department or clinic.

Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30) unless the beneficiary is diagnosed with chronic pain or is being treated for pain management. Beneficiaries diagnosed with chronic pain or being treated for pain management are limited to one thousand eight hundred dollars ($1,800) per SFY for diagnostic laboratory services. ~~, and r~~Radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

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

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

(2) Services for pregnant women are specifically exempt from the per SFY diagnostic laboratory services benefit limit, and the per SFY radiology/other services health benefit limits. The cost of related diagnostic laboratory services and radiology/other services will not be included in the calculation of the beneficiary's per SFY diagnostic laboratory services benefit limit or the per SFY radiology/other services health benefit limit.

~~(1)~~

~~(2)~~(3) Drug screening will be specifically exempt from the ~~five hundred dollars ($500)~~ per SFY diagnostic laboratory services health benefit limit when the diagnosis is for Opioid Use Disorder (OUD), and the screening is part of a Medication Assisted Treatment (MAT) plan. The cost of these screenings will not be included in the calculation of the ~~recipient's five hundred dollars ($500)~~ beneficiary's diagnostic laboratory or radiology/other services health benefit limits.

~~(3)~~(4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the ~~five hundred dollars ($500)~~ per SFY outpatient diagnostic laboratory services benefit limit ~~or~~ and ~~five hundred dollars ($500)~~ per SFY radiology/other services health benefit limit. The cost of these procedures will not be included in the calculation of the ~~recipient's five hundred dollars ($500)~~beneficiary's per SFY diagnostic laboratory services benefit limit or the ~~recipient's five hundred dollars ($500)~~ beneficiary's per SFY radiology/other services health benefit limit.

~~(4)~~(5) Portable X-Ray Services are subject to the ~~five hundred dollars ($500)~~ per SFY X-ray services benefit limit. Extensions of the benefit limit for ~~recipients~~ beneficiaries twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible ~~recipient~~ beneficiary in their residence upon the written order of the ~~recipient's~~ beneficiary's physician. Portable X-ray services are limited to the following:

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

~~(5)~~(6) Two (2) chiropractic X-rays are covered per SFY. Chiropractic X-Ray Services are subject to the ~~five hundred dollars ($500)~~ benefit limit per SFY for radiology/other services. Extensions of the radiology/other services benefit limit for ~~recipients~~ beneficiaries twenty-one (21) years of age or older will be provided through prior authorization, if medically necessary.

MARKUP

4. a. Nursing Facility Services - Not Provided

MARK-UP

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION _____
PERSON COMPLETING THIS STATEMENT Andy Morgan
TELEPHONE NO. (501) 534-4125 **EMAIL** Andy.Morgan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Diagnositc Laboratory Services Annual Cap Change for Chronic Pain and Pain Management

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ☑ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
   Yes ☑ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☑ No ☐

   If no, please explain:

   (a) how the additional benefits of the more costly rule justify its additional cost;

   (b) the reason for adoption of the more costly rule;

   (c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$	General Revenue	$
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$150,004	General Revenue	$301,567
Federal Funds	$337,496	Federal Funds	$673,433
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$487,500	Total	$975,000

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**
$ 0	$ 0

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ 150,004.00	$ 301,567.00

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☑ No ☐

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

FINANCIAL IMPACT STATEMENT ADDENDUM

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☒ No ☐

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

To comply with Act 567 of 2025.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

Implement new lab limits established by Act 567 of 2025.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This rule implements Act 567 of 2025. In Act 567, the General Assembly of the State of Arkansas increased the benefit limits for beneficiaries diagnosed with chronic pain or being treated for pain management.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

N/A at this time.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

N/A. Rule implements Act 567 of 2025.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control cost.

Statement of Necessity and Rule Summary

Diagnostic Laboratory Services Annual Cap Change for Chronic Pain and Pain Management

Statement of Necessity

This rule implements Act 567 of 2025. In Act 567, the General Assembly increased the benefit limits for beneficiaries diagnosed with chronic pain or being treated for pain management.

Summary

To implement the Act, the Division of Medical Services amends the following Medicaid Provider Manuals and the Arkansas Medicaid State Plan. The changes increase the annual reimbursement cap for beneficiaries from $500 per state fiscal year to $1800 per state fiscal year if they have been diagnosed with chronic pain or are receiving services for pain management.

- This rule will amend the sections stated below for the following provider manuals:
    - Ambulatory Surgical Center: 215.110, 215.120, 215.121, and 215.122;
    - Certified Nurse Midwife: 213.400, 213.410, 213.420, 214.100, 214.110, 214.120;
    - Chiropractic: 214.110, 214.120;
    - Hospital: 215.040, 215.100, 215.101, 272.435;
    - Nurse Practitioner: 214.510, 214.910, 214.920, 214.930; and
    - Physician:225.100, 229.100, 229.110, 229.120, and 292.831.
- Arkansas Medicaid State Plan pages 3.1-A.1f and 3.1-Bf.

Please attach additional documents if necessary

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20 77-107, and 25-10-129. The projected effective date of the rule is January 1, 2026.

The Division of Medical Services (DMS) implements Acts 567 of 2025. To implement the Act, DMS amends the Arkansas Medicaid State Plan and the Ambulatory Surgical Center, Certified Nurse Midwife, Chiropractic, Hospital, Nurse Practitioner, and Physician Medicaid Provider Manuals to increase the annual reimbursement cap for beneficiaries from $500 per state fiscal year to $1800 per state fiscal year if they have been diagnosed with chronic pain or receiving services for pain management. The estimated financial impact is $487,000.00 for state fiscal year 2026 and $975,000.00 for state fiscal year 2027.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than November 1, 2025. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held by remote access through Zoom. Public comments may be submitted at the hearing. The details for attending the Zoom hearing appear at ar.gov/dhszoom.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4502292178**

Elizabeth Pitman, Director
Division of Medical Services