EXHIBIT H

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Ambulatory Surgical Center Manual (ASC-1-19)

DESCRIPTION:

Statement of Necessity

The purpose of this rule is to bring all Ambulatory Surgical Center (ASC) procedure codes up to date so that the ASC codes conversion can occur in conjunction with the annual Physician's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes conversions. In addition, the revision is necessary to bring the Division of Medical Services (DMS) payment policy processes up to date now that our new InterChange has been implemented and can be used to ensure timely compliance with updates.

Rule Summary

Effective for dates of service on or after June 1, 2020, procedure codes that require medical review, prior authorization, or diagnosis restriction are being removed from the text of the Ambulatory Surgical Center (ASC) Provider Manual and are being replaced with a hyperlink to a list of the procedure codes. The procedure codes are being removed from the manual pursuant to Ark. Code Ann. § 25-15-202(9)(B)(iv) and to allow for faster updates when national procedure codes change. The State Plan reimbursement methodology requires an annual review of the changes in procedure codes payable to ASCs based on the year's Medicare ASC Fee Schedule.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired March 30, 2020. The agency indicated that it received no public comments.

The proposed effective date is June 1, 2020.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the authority to administer assigned forms of public assistance and to make rules as necessary to carry out its duties. Ark. Code Ann. § 20-76-201(1), (12). The Department is specifically tasked with establishing and maintaining an indigent medical care program. Ark. Code Ann. § 20-77-107(a)(1). This includes promulgating rules to ensure compliance with federal law in order to receive federal funding. Ark. Code Ann. § 25-10-129(b). The Arkansas Administrative Procedures Act does not govern changes to medical codes used by Arkansas Medicaid. Ark. Code Ann. § 25-15-202(9)(B)(iv).

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Janet Mann
CONTACT PERSON Alexandra Rouse
ADDRESS PO Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. 501-508-8875 **FAX NO.** 501-404-4619 **E-MAIL** Alexandra.Rouse@dhs.arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Janet Mann
PRESENTER E-MAIL Janet.Mann@dhs.arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2 copies of the proposed rule and required documents. Mail or deliver to:

Jessica C. Sutton
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Ambulatory Surgical Center Manual (ASC-1-19)

2. What is the subject of the proposed rule? Effective 6-1-20, updated procedure codes will be removed from the Ambulatory Surgical Center Provider Manual.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☐ No ☒
   If yes, please provide the federal rule, regulation, and/or statute citation. _____

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ☐ No ☒
   If yes, what is the effective date of the emergency rule? _____
   When does the emergency rule expire? _____
   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act?
   Yes ☐ No ☐

5. Is this a new rule? Yes ☐ No ☒

If yes, please provide a brief summary explaining the regulation. _____

Does this repeal an existing rule? Yes ☐ No ☒
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. _____

Is this an amendment to an existing rule? Yes ☒ No ☐
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should b clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

7. What is the purpose of this proposed rule? Why is it necessary? See attached.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b). https://medicaid.mmis.arkansas.gov/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes ☐ No ☒
If yes, please complete the following:

Date: _____
Time: _____
Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
March 30, 2020

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
June 1, 2020

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See attached.

14. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known. Unknown.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services 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.

Effective for dates of service on or after June 1, 2020, procedures codes that require medical review, prior authorization, or diagnosis restriction are being removed from the text of the Ambulatory Surgical Center Provider Manual and are being replaced with a hyperlink to a list of the procedure codes. The procedure codes are being removed from the manual pursuant to Ark. Code Ann. § 25-15-202(9)(B)(iv) and to allow for faster updates when national procedure codes change. The State Plan reimbursement methodology requires an annual review of the changes in procedure codes payable to Ambulatory Surgical Centers (ASC) based on the year's Medicare ASC Fee Schedule.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 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 on the Medicaid website at https://medicaid.mmis.arkansas.gov/General/Comment/Comment.aspx. Public comments must 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 March 30, 2020. 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.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6164.

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. **4501888131**

Janet Mann

Janet Mann, Director
Division of Medical Services

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Lynn Burton

TELEPHONE 501-682-1857 **FAX** 501-404-4619 **EMAIL:** Lynn Burton @dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Ambulatory Surgical Center (ASC-1-19)

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 an agency is proposing a more costly rule, please state the following:

   (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 more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

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	0	General Revenue	0
Federal Funds	0	Federal Funds	0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	0	Total	0

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

Current Fiscal Year	Next Fiscal Year
$	$

6. What is the total estimated cost by fiscal year to state, county, and 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
$ 0	$ 0

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.

Statement of Necessity and Rule Summary

Ambulatory Surgical Center Manual (ASC-1-19)

Statement of Necessity

The purpose of this rule is to bring all Ambulatory Surgical Center (ASC) procedure codes up to date so that the ASC codes conversion can occur in conjunction with the annual Physician's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes conversions. In addition, the revision is necessary to bring the Division of Medical Services (DMS) payment policy processes up to date now that our new InterChange has been implemented and can be used to ensure timely compliance with updates.

The procedure codes are being removed from the manual pursuant to Ark. Code Ann. § 25-15-202(9)(B)(iv) and to allow for faster updates when national procedure codes change. The State Plan reimbursement methodology requires an annual review of the changes in procedure codes payable to Ambulatory Surgical Centers (ASC) based on the year's Medicare ASC Fee Schedule.

Rule Summary

Effective for dates of service on or after June 1, 2019, procedures codes that require medical review, prior authorization, or diagnosis restriction are being removed from the text of the Ambulatory Surgical Center Provider Manual and are being replaced with a hyperlink to a list of the procedure codes. The procedure codes are being removed from the manual pursuant to Ark. Code Ann. § 25-15-202(9)(B)(iv) and to allow for faster updates when national procedure codes change. The State Plan reimbursement methodology requires an annual review of the changes in procedure codes payable to Ambulatory Surgical Centers (ASC) based on the year's Medicare ASC Fee Schedule.

TOC required

222.000 **ASC Procedures ~~Outpatient Surgeries~~That Require Medical Review, Prior Authorization, and Diagnosis Code Restriction** ~~11-1-17~~6-1-20

~~A. For dates of service on or after November 1, 2017 the following procedure codes require prior authorization.~~

~~11920~~	~~11921~~	~~11950~~	~~11951~~	~~11952~~	~~11954~~	~~15775~~	~~15776~~
~~15780~~	~~15781~~	~~15782~~	~~15783~~	~~15789~~	~~15819~~	~~15820~~	~~15821~~
~~15822~~	~~15823~~	~~15824~~	~~15825~~	~~15826~~	~~15828~~	~~15829~~	~~15876~~
~~15877~~	~~15878~~	~~15879~~	~~17360~~	~~17380~~	~~21073~~	~~26341~~	~~27279~~
~~28531~~	~~36468~~	~~43886~~	~~43887~~	~~43888~~	~~54401~~	~~54405~~	~~54406~~
~~54408~~	~~54410~~	~~54900~~	~~54901~~	~~55870~~	~~56805~~	~~58321~~	~~58322~~
~~58323~~	~~58970~~	~~58974~~	~~58976~~	~~59200~~	~~64566~~	~~C9724~~	

A. The procedure codes found in the following link require medical review, prior authorization, or diagnosis restriction as of the effective date indicated. **View or print the procedure codes for ASC services.**

B. For dates of service on or after November 1, 2017 the following procedure codes require prior authorization.

Outpatient Surgery Abortion Codes That Require Prior Authorization		
59840	59841	59866

1. Refer to Section 216.110, "Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term," for the prior authorization process.
2. Refer to Section 216.120, "Abortion When the Pregnancy Is a Result of Rape or Incest," for the prior authorization process.
3. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report attached. **View a sample CMS-1450 (UB-04) claim form. View or print form DMS-2698.**

~~242.411 Other Covered Injections and Immunizations with Special Instructions~~ ~~11-1-17~~

~~For dates of service on or after November 1, 2017, the following procedure codes require prior authorization or a diagnosis restriction.~~

~~The following is a list of injections with special instructions for coverage and billing. The table of payable procedure codes is designed with eight columns of information.~~

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

~~B. The **second** column indicates specific ICD primary diagnosis restrictions.~~

~~C. The **third** column contains information about the "diagnosis list" for which a procedure code may be used.~~

D. The **fourth** column indicates whether a procedure is subject to medical review before payment.

E. The **fifth** column indicates a procedure code requires a prior authorization before the service is provided.

Procedure Code	Diagnosis	Diagnosis List	Review	PA
A9520	No	No	No	No
A9586	No	No	No	No
C9025	No	List 103	No	No
C9026	No	No	No	Yes
C9027	No	No	No	Yes
C9132	No	No	Yes	No

NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9257	No	No	No	Yes
C9442	No	No	No	Yes
C9445	No	No	No	No
C9449	No	No	No	Yes
C9450	No	No	No	Yes
C9451	J10.1	No	No	No
C9453	No	No	No	Yes
C9454	No	No	No	Yes
C9455	No	No	No	Yes
J0401	No	List 157	No	Yes
J0717	No	No	No	Yes
J1322	No	No	No	Yes
J1556	No	No	Yes	No
J1602	No	No	Yes	No
J3060	No	No	Yes	Yes
J3101	No	No	Yes	No
J7316	No	No	Yes	Yes
J7321	No	No	No	Yes
J7323	No	No	No	Yes
J7324	No	No	No	Yes

Procedure Code	Diagnosis	Diagnosis List	Review	PA
J7325	No	No	No	Yes
	NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 220.000 for prior authorization information. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. **Hyaluronon** is limited to one injection or series of injections per knee, per beneficiary, per lifetime. A maximum of three injections per knee are allowed of **Hylan** polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures. Refer to Section 220.000 for prior authorization.			
J7327	No	No	No	Yes
J7336	No	No	No	Yes
J9047	No	No	No	Yes
J9262	No	No	No	Yes
J9301	No	No	No	Yes
J9306	No	No	No	Yes
J9354	No	No	No	Yes
J9371	No	No	No	Yes
J9400	No	No	Yes	Yes
Q3027	No	List 166	No	Yes
Q9975	No	No	No	Yes
Q9978	No	No	No	Yes

TOC required

222.000 ASC Procedures That Require Medical Review, Prior Authorization, and Diagnosis Code Restriction 6-1-20

A. The procedure codes found in the following link require medical review, prior authorization, or diagnosis restriction as of the effective date indicated. **View or print the procedure codes for ASC services**.

B. For dates of service on or after November 1, 2017 the following procedure codes require prior authorization.

Outpatient Surgery Abortion Codes That Require Prior Authorization		
59840	59841	59866

1. Refer to Section 216.110, "Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term," for the prior authorization process.
2. Refer to Section 216.120, "Abortion When the Pregnancy Is a Result of Rape or Incest," for the prior authorization process.
3. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report attached. **View a sample CMS-1450 (UB-04) claim form. View or print form DMS-2698.**

TOC required

216.400 ~~Reserved~~Family Planning ~~7-1-14~~7-1-17

The following procedure codes are being added to the Ambulatory Surgical Center program for females with a primary diagnosis of family planning when billed with modifier SG:

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

11976	11981	55250	55450	57150	58300	58301	58600
58615	58661*	58670	58671	72190	J1050	J7301	

*CPT code 58661 represents a procedure to treat medical conditions as well as for elective sterilizations.

~~**216.910 Other Covered Injections and Immunizations with Special Instructions** 7-1-14~~

~~Procedure Code~~	~~Modifier~~	~~Age Restriction~~	~~Diagnosis~~	~~Diagnosis List~~	~~Review~~	~~PA~~	~~Prior Approval Letter~~
~~J7321~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~Yes~~	~~No~~
~~J7323~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~Yes~~	~~No~~
~~J7324~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~Yes~~	~~No~~
~~J7325~~	~~No~~	~~No~~	~~No~~	~~No~~	~~No~~	~~Yes~~	~~No~~

~~NOTE: Prior authorization is required for coverage of the Viscosupplementation injection in the ASC for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for these procedure codes. A written request must be submitted to the Division of Medical Services Utilization Review Section. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, ASC Arkansas Medicaid Provider number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments, results and site of injection.~~

221.100 Prior Authorization Request and Notification Procedures 7-1-14~~17~~

The procedures in this section apply to all requests for PA of outpatient surgeries.

A. The attending physician or the physician's office nurse (or a licensed physician assistant) must furnish the following information by telephone to AFMC.

1. The beneficiary's name and address
2. The beneficiary's Medicaid identification number
3. The physician's name and state license number
4. The physician's provider identification number
5. The facility's name
6. The date of the procedure

mark-up

B. AFMC approves or denies the request by telephone and follows up with written confirmation of the determination.

1. In approved cases, AFMC assigns a prior authorization control number to the case.
2. When AFMC denies a PA request, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of this manual).

C. AFMC forwards individual written confirmation to the surgeon.

D. It is important to note that the surgeon is ultimately responsible for ensuring that the facility (as well as any other affected provider, such as the anesthetist) has a copy of the authorization to file and to use for billing purposes.

E. When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your requests 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	(479) 649-0799
Web portal	https://afmc.org/reviewpoint/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

222.000 Outpatient Surgeries That Require Prior Authorization 7-1-1417

A. The following procedure codes require prior authorization.

11920	11921	11950	11951	11952	11954	15775	15776
15780	15781	15782	15783	15789	15819	15820	15821
15822	15823	15824	15825	15826	15828	15829	15876
15877	15878	15879	17360	17380	21073	26341	27279

mark-up

28531	36468	43886	43887	43888	54401	54405	54406
54408	54410	54900	54901	55870	56805	58321	58322
58323	58970	58974	58976	59200	64566	C9724	

Outpatient Surgeryies Abortion Codes That Require Prior Authorization		
59840	59841	59866

A1. Refer to Section 216.110, "Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term," for the prior authorization process.

B2. Refer to Section 216.120, "Abortion When the Pregnancy Is a Result of Rape or Incest," for the prior authorization process.

C3. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report attached. **View a sample CMS-1450 (UB-04) claim form. View or print form DMS-2698.**

223.000 **Prior Authorization of ViscosupplementationReserved** 7-1-1417

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

B. Prior authorization is required for coverage of the Viscosupplementation in the ASC for procedure codes **J7321, J7323, J7324 and J7325.** Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. The PA request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, ASC Arkansas Medicaid Provider number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection.

242.411 **Other Covered Injections and Immunizations with Special Instructions** 7-1-17

The following is a list of injections with special instructions for coverage and billing. The table of payable procedure codes is designed with eight columns of information.

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

B. The **second** column indicates specific ICD primary diagnosis restrictions.

C. The **third** column contains information about the "diagnosis list" for which a procedure code may be used.

D. The **fourth** column indicates whether a procedure is subject to medical review before payment.

E. The **fifth** column indicates a procedure code requires a prior authorization before the service is provided.

Procedure Code	Diagnosis	Diagnosis List	Review	PA
A9520	**View ICD Codes.**	No	No	No

Mark-up

Procedure Code	Diagnosis	Diagnosis List	Review	PA
A9580	No	No	No	No
A9586	**View ICD Codes.**	No	No	No
C9132	**View ICD Codes.**	No	Yes	No

NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9445*	No	No	No	No
C9451	J10.1	No	No	No
J0401	No	List 157	No	Yes
J0717	No	No	No	Yes
J1322	No	No	No	Yes
J1556*	No	No	Yes	No
J1602*	No	No	Yes	No
J3060*	No	No	Yes	Yes
J3101	No	No	Yes	Yes
J7316*	**View ICD Codes.**	No	Yes	Yes
J7321	No	No	No	Yes
J7323	No	No	No	Yes
J7324	No	No	No	Yes
J7325	No	No	No	Yes

NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 220.000 for prior authorization information. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. **Hyaluronon** is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections per knee are allowed of **Hylan** polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures. Refer to Section 220.000 for prior authorization.

mark-up

Procedure Code	Diagnosis	Diagnosis List	Review	PA
J7336	No	No	No	No
J9047*	No	No	Yes	Yes
J9262*	**View ICD Codes.**	No	Yes	Yes
J9301	No	No	No	Yes
J9306*	**View ICD Codes.**	No	Yes	Yes
J9354*	**View ICD Codes.**	No	Yes	Yes
J9371*	**View ICD Codes.**	No	Yes	Yes
NOTE: **Marqibo** is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.				
J9400*	No	No	Yes	Yes
Q3027	No	List 166	No	Yes
Q9975	No	No	No	Yes
Q9978	No	No	No	Yes

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

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

EFFECTIVE DATE: **November 1, 2017**

SUBJECT: **Provider Manual Update Transmittal ASC-1-17**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
216.400	7-1-14	216.400	11-1-17
216.910	7-1-14	—	—
221.100	7-1-14	221.100	11-1-17
222.000	7-1-14	222.000	11-1-17
223.000	7-1-14	223.000	11-1-17
—	—	242.411	11-1-17

Explanation of Updates

Section 216.400 has been updated with family planning procedure codes.

Section 216.910 has been removed.

Section 221.100 has been updated with information about obtaining a prior authorization from AFMC.

Section 222.000 has been updated with the most recent information pertaining to outpatient surgeries that require prior authorization.

Section 242.411 has been added with information regarding other covered injections and immunizations with special instruction.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle/TSH

Dawn Stehle
Director

TOC required

216.400 Family Planning **7-1-17**

The following procedure codes are being added to the Ambulatory Surgical Center program for females with a primary diagnosis of family planning when billed with modifier SG:

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

11976	11981	55250	55450	57150	58300	58301	58600
58615	58661*	58670	58671	72190	J1050	J7301	

*CPT code 58661 represents a procedure to treat medical conditions as well as for elective sterilizations.

221.100 Prior Authorization Request and Notification Procedures **7-1-17**

The procedures in this section apply to all requests for PA of outpatient surgeries.

A. The attending physician or the physician's office nurse (or a licensed physician assistant) must furnish the following information by telephone to AFMC.

1. The beneficiary's name and address
2. The beneficiary's Medicaid identification number
3. The physician's name and state license number
4. The physician's provider identification number
5. The facility's name
6. The date of the procedure

B. AFMC approves or denies the request by telephone and follows up with written confirmation of the determination.

1. In approved cases, AFMC assigns a prior authorization control number to the case.
2. When AFMC denies a PA request, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of this manual).

C. AFMC forwards individual written confirmation to the surgeon.

D. It is important to note that the surgeon is ultimately responsible for ensuring that the facility (as well as any other affected provider, such as the anesthetist) has a copy of the authorization to file and to use for billing purposes.

E. When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your requests 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	(479) 649-0799
Web portal	https://afmc.org/reviewpoint/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

222.000 Outpatient Surgeries That Require Prior Authorization 7-1-17

A. The following procedure codes require prior authorization.

11920	11921	11950	11951	11952	11954	15775	15776
15780	15781	15782	15783	15789	15819	15820	15821
15822	15823	15824	15825	15826	15828	15829	15876
15877	15878	15879	17360	17380	21073	26341	27279
28531	36468	43886	43887	43888	54401	54405	54406
54408	54410	54900	54901	55870	56805	58321	58322
58323	58970	58974	58976	59200	64566	C9724	

Outpatient Surgery Abortion Codes That Require Prior Authorization		
59840	59841	59866

1. Refer to Section 216.110, "Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term," for the prior authorization process.
2. Refer to Section 216.120, "Abortion When the Pregnancy Is a Result of Rape or Incest," for the prior authorization process.
3. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report attached. **View a sample CMS-1450 (UB-04) claim form. View or print form DMS-2698.**

223.000 Reserved 7-1-17

242.411 Other Covered Injections and Immunizations with Special Instructions 7-1-17

The following is a list of injections with special instructions for coverage and billing. The table of payable procedure codes is designed with eight columns of information.

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

B. The **second** column indicates specific ICD primary diagnosis restrictions.

C. The **third** column contains information about the "diagnosis list" for which a procedure code may be used.

D. The **fourth** column indicates whether a procedure is subject to medical review before payment.

E. The **fifth** column indicates a procedure code requires a prior authorization before the service is provided.

Procedure Code	Diagnosis	Diagnosis List	Review	PA
A9520	View ICD Codes.	No	No	No
A9580	No	No	No	No
A9586	View ICD Codes.	No	No	No
C9132	View ICD Codes.	No	Yes	No

NOTE: **Kcentra** is indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKZ, e.g. warfarin) therapy in adult patients with major bleeding. **Kcentra** is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding. Documentation of the major bleed should be included in a complete history and physical exam. All treatments needed for the major bleed prior to **Kcentra** should be documented. A hemoglobin and hematocrit should be documented in the record as well as the dose of warfarin.

C9445*	No	No	No	No
C9451	J10.1	No	No	No
J0401	No	List 157	No	Yes
J0717	No	No	No	Yes
J1322	No	No	No	Yes
1556*	No	No	Yes	No
J1602*	No	No	Yes	No
J3060*	No	No	Yes	Yes
J3101	No	No	Yes	Yes
J7316*	View ICD Codes.	No	Yes	Yes
J7321	No	No	No	Yes
J7323	No	No	No	Yes

Procedure Code	Diagnosis	Diagnosis List	Review	PA
J1556*	No	No	Yes	No
J1602*	No	No	Yes	No
J3060*	No	No	Yes	Yes
J3101	No	No	Yes	Yes
J7316*	View ICD Codes.	No	Yes	Yes
J7321	No	No	No	Yes
J7323	No	No	No	Yes
J7324	No	No	No	Yes
J7325	No	No	No	Yes

NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324 and J7325. Providers must specify the brand name of **Hyaluronon** (sodium hyaluronate) or derivative when requesting prior authorization for this procedure code. A written request must be submitted to the Division of Medical Services Utilization Review Section. Refer to Section 220.000 for prior authorization information. The request must include the patient's name, Medicaid ID number, physician's name, physician's Arkansas Medicaid provider identification number, patient's date of birth and medical records that document the severity of osteoarthritis, previous treatments and site of injection. **Hyaluronon** is limited to one injection or series of injections per knee, per beneficiary, per lifetime.

A maximum of three injections per knee are allowed of **Hylan** polymers that are covered by Arkansas Medicaid. If additional injections are administered as part of the initial series, the cost of the additional injections is considered a component of the other approved unit(s) of these injection procedures. Refer to Section 220.000 for prior authorization.

J7336	No	No	No	No
J9047*	No	No	Yes	Yes
J9262*	View ICD Codes.	No	Yes	Yes
J9301	No	No	No	Yes
J9306*	View ICD Codes.	No	Yes	Yes
J9354*	View ICD Codes.	No	Yes	Yes
J9371*	View ICD Codes.	No	Yes	Yes

NOTE: **Marqibo** is a vinca alkaloid indicated for the treatment of adult patients with Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia in second or greater relapse or whose disease has progressed following two or more anti-leukemic therapies. A complete history and physical exam documenting all previous therapies should be submitted. Approval will be on a case-by-case basis.

J9400*	No	No	Yes	Yes
Q3027	No	List 166	No	Yes
Q9975	No	No	No	Yes

Procedure Code	Diagnosis	Diagnosis List	Review	PA
Q9978	No	No	No	Yes

Stricken language would be deleted from and underlined language would be added to present law.
Act 1236 of the Regular Session

State of Arkansas *As Engrossed: S3/17/15 S3/26/15*
90th General Assembly **A Bill**
Regular Session, 2015 SENATE BILL 1019

By: Senator Irvin

For An Act To Be Entitled

AN ACT TO AMEND THE ACCESS TO CARE ACT, *§ 20-77-129*; TO LOWER THE COST OF CARE AND INCREASE ACCESS TO CARE FOR MEDICAID *PATIENTS; TO DECLARE AN EMERGENCY; AND* FOR OTHER PURPOSES.

Subtitle

TO AMEND THE ACCESS TO CARE ACT, § 20-77-129; AND TO LOWER THE COST OF CARE AND INCREASE ACCESS TO CARE FOR MEDICAID PATIENTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 20-77-129 is amended to read as follows:

20-77-129. Ambulatory surgery centers — Medicaid reimbursement.

(a) As used in this section:

(1) "Ambulatory surgery center" means ~~a distinct~~ an entity certified by Medicare as an ambulatory surgical center that operates ~~exclusively~~ for the purpose of providing surgical services to patients ~~not requiring hospitalization~~ and that is eligible to receive reimbursement from Medicaid for ambulatory surgery services;

(2) "Ambulatory Surgery Center Medicaid Procedure Code" means appropriate:

(A) Current Procedural Terminology codes representing procedures that do not appear on the Medicare hospital inpatient-only list or Medicaid hospital inpatient-only list and that are medically necessary and not solely for cosmetic treatment or surgery; or

(B) Comparable Current Procedural Terminology codes adopted and assigned under this section, representing procedures that do not appear on the Medicaid hospital inpatient only list, are medically necessary, and are not solely for cosmetic treatment or surgery;

~~(3) "Ambulatory Surgery Center Medicaid reimbursement formula for appropriate implantable devices" means appropriate implantable devices used during appropriate procedures that are reimbursed at a pass through cost if the combined cost of the appropriate implantable devices is greater than fifty percent (50%) of the reimbursement for the Ambulatory Surgery Center Medicaid Procedure Code;~~

~~(4)~~ "Ambulatory Surgical Center Medicaid reimbursement rate for appropriate procedures" means ~~eighty percent (80%)~~ ninety-five percent (95%) of ~~hospital outpatient procedure department~~ ambulatory surgical center Medicare reimbursement that is currently effective for applicable Ambulatory Surgical Center Medicaid Procedure Codes;

~~(5) "Appropriate implantable device" means a device used during an appropriate procedure;~~

~~(6)~~(4) "Appropriate procedure" means a surgical procedure or other procedure commonly performed in an ambulatory surgery center setting that is not on:

(A) ~~the~~ The Medicaid hospital inpatient-only list or Medicare hospital inpatient-only list; or

(B) The Medicaid hospital inpatient-only list for which a comparable Current Procedural Terminology code has been adopted and assigned under this section;

~~(7) "Healthcare Financing Administration Common Procedure Coding System" means the coding system under the Centers for Medicare and Medicaid Services;~~

(5) "Current Procedural Terminology code" means the codes that are commonly used in the healthcare industry to identify services that are provided;

~~(8)~~(6) "Hospital inpatient-only list" means a listing kept by the Centers for Medicare and Medicaid Services of procedures that should be performed on an inpatient basis only with separately recorded lists for Medicare and Medicaid ~~for the Medicare population due to one (1) or more of the following reasons:~~

~~(A) The nature of the procedure;~~

~~(B) The need for at least twenty four (24) hours of postoperative care; and~~

~~(C) The underlying physical condition of those patients most often having the particular procedure;~~

~~(9)~~(7) "Hospital outpatient procedure department" means a hospital-based ambulatory surgery center that bills in accordance with the Outpatient Hospital Services Medicaid Provider Guide; and

~~(10)~~(8) "Relative Value Unit" means a service unit value measured in relation to the values of other services and involving a Current Procedural Terminology code that, when multiplied by the conversion factor and a geographical adjustment, creates the compensation level for a particular service.

(b) The purpose of this act is to decrease ~~the cost of~~ costs to Medicaid while increasing access to care to Arkansas's Medicaid population.

(c)(1) An appropriate procedure may be performed at an ambulatory surgery center or a hospital outpatient procedure department.

(2) If an appropriate procedure is performed at an ambulatory surgery center ~~or at a hospital outpatient procedure department~~, the appropriate procedure and any appropriate implantable devices shall be billed using the Ambulatory Surgery Center Medicaid Procedure Codes and reimbursed pursuant to the Ambulatory Surgery Center Medicaid reimbursement ~~formula~~ rate for appropriate procedures ~~and the Ambulatory Surgical Center Medicaid reimbursement formula for appropriate implantable devices~~.

~~(d) If an Ambulatory Surgery Center Medicaid Procedure Code is not on the Medicaid hospital inpatient only list but is on the Medicare hospital inpatient only list, the Ambulatory Surgery Center Medicaid reimbursement formula for appropriate procedures shall be eighty percent (80%) of the Medicare hospital outpatient procedure department reimbursement for a comparable procedure, based on a Relative Value Unit that is not on the Medicare hospital inpatient only list.~~

(d)(1) Upon request by, and in consultation with, the Arkansas Ambulatory Surgery Association, its successor, or an ambulatory surgery center, the Department of Human Services may adopt and assign an appropriate Current Procedural Terminology code for an appropriate procedure, based on a Relative Value Unit for a comparable procedure not on the Medicaid hospital

inpatient-only list, if the appropriate procedure:

(A) Is not on the Medicaid hospital inpatient-only list but is on the Medicare hospital inpatient-only list; or

(B) Is a medically necessary surgical service that is not on the Medicaid hospital inpatient-only list, for which there is no corresponding reimbursement value recited in the current Medicare ambulatory surgery center fee schedule.

(2) A comparable Current Procedural Terminology code adopted and assigned under this section shall be reimbursed at ninety-five percent (95%) of the Medicare ambulatory surgical center reimbursement rate for the comparable procedure.

(3) A request for the adoption and assignment of a comparable Current Procedural Terminology code shall be submitted and approved before the appropriate procedure is performed.

(e) A reimbursement payment made under this section may not exceed the Medicaid upper payment limit as established by the Centers for Medicare and Medicaid Services.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that reimbursements under the Arkansas Medicaid Program are subject to federal upper payment limits; that reimbursements under the current law may exceed the federal upper payment limits, requiring the excess cost to be funded entirely through state general revenues; and that this act is immediately necessary to protect the fiscal integrity of the Arkansas Medicaid Program. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

APPROVED: 04/07/2015