DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES

SUBJECT: 2012 Current Procedure Terminology (CPT) & Healthcare Common Procedural Coding System Level II (HCPC) Code Conversions

DESCRIPTION: To be in compliance with federal regulation 45 CFR Part 45 Section 162.1002, these notices inform providers of the implementation of the annual Current Procedure Codes (CPT) and the annual Healthcare Common Procedure Codes (HCPCS) systems. These data sets are created and published by the American Medical Association and the Centers for Medicare and Medicaid respectively on an annual basis. This rule is necessary for consistency with the utilization of procedure codes used by Medicare and other third party payers of medical claims. These data sets are standardized and are used nationally for claims processing.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on June 12, 2012. No public comments were submitted. This rule was filed under the emergency provisions of the Administrative Procedure Act with an emergency effective date of May 11, 2012. The proposed effective date for permanent promulgation is September 1, 2012.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: This will made a minimal impact. It is an annual requirement for all providers.

The Arkansas Medicaid Program's annual CPT and HCPCS code change conversion process (additions of new codes and deletions of existing codes) is necessary under HIPAA requirements. These annual coding changes require the Arkansas Medicaid Program (1) to make decisions as to whether to cover newly created codes; and (2) to cease coverage of all deleted codes. These 5 digit CPT and HCPCS codes are used by providers to bill and be reimbursed by the Arkansas Medicaid Program on a fee-for-service basis. All national medical payers and providers, in addition to the Arkansas Medicaid Program, must annually make these same adjustments to comply with these new coding requirements. While there are some new services added every year, most new added codes are generally revised description replacement codes for existing or similar deleted codes. This replacement situation occurs because new codes are created to more accurately identify the services now being performed. Sometimes the new code expands the description of an existing services and sometimes the new code decreases or separates into two new distinct service descriptions of an existing service. The department has reviewed the actual results of these coding change conversions for the last several years and has determined that no budget impact was realized. The department is estimating that there will be no budget impact for 2012 based on the results of the previous years that they reviewed.

LEGAL AUTHORIZATION: Arkansas Code § 20-76-201 authorizes the Department of Human Services to administer programs for the indigent and to "make rules and regulations" pertaining to the administration of those programs. Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

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

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Lisa Smith
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8363 **FAX NO.** 682-2480 **E-MAIL** lisa.smith.dms@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@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:**

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

Notice of Rule Making - 2012 Current Procedure Terminology (CPT®) Code Conversion
Notice of Rule Making – 2012 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion

2. What is the subject of the proposed rule?

To inform providers of the 2012 Healthcare Common Procedural Coding System (HCPCS) Level II and 2012 Current Procedure Terminology (CPT) Code Conversions

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

45 CFR Subpart A Section 162.1002 and the Health Insurance Portability and Accountability Act of 1996.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
Yes X No____.

If yes, what is the effective date of the emergency rule?

May 11, 2012

When does the emergency rule expire?

September 8, 2012

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes _X_ No____.

5. Is this a new rule? Yes _X_ No ____ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No__**X**_ 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 _X_ 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 be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

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

   The purpose of the proposed rule is to be in compliance with federal regulation 45 CFR Part 45 Section 162.1002. These notices inform providers of the implementation of the annual Current Procedure Terminology Codes (CPT) and the annual Healthcare Common Procedure Codes (HCPCS) systems and make non payable those deleted procedure codes from the 2011 code books. This rule is necessary for consistency with utilization of procedure codes used by Medicare and other third party payers of medical claims.

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://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes_____ No _X_.
   If yes, please complete the following:
   Date:_____
   Time:_____
   Place:_____

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

    June 12, 2012

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

    September 1, 2012 (Adopted by Federal Regulation 5/11/12)

12. Do you expect this rule to be controversial? Yes_____ No _X_ If yes, please explain.

13. 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.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Tom Show
TELEPHONE NO. 682-2483 **FAX NO.** 682-2480 **EMAIL:** tom.show@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Notice of Rule Making - 2012 CPT & HCPCS Code Conversion

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

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes ____ No __X__. **(Minimal impact; annual requirement for all providers.)**

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

   The Arkansas Medicaid Program's annual CPT and HCPCS code change conversion process (additions of new codes and deletions of existing codes) is necessary under HIPAA requirements. These annual coding changes require the Arkansas Medicaid Program: (1) to make decisions as to whether to cover newly created codes and (2) requires us to cease coverage of all deleted codes. These 5 digit CPT and HCPCS codes are used by providers to bill and be reimbursed by the Arkansas Medicaid Program on a fee-for-services basis. All national medical payers and providers, in addition to the Arkansas Medicaid Program, must annually make these same adjustments to comply with these new coding requirements. While there are some new services added every year, most new added codes are generally revised description replacement codes for existing or similar deleted codes. This replacement situation occurs because new codes are created to more accurately identify the services now being performed. Sometimes the new code expands the description of an existing service and sometimes the new code decreases or separates into two new distinct service descriptions of an existing service. We have reviewed the actual results of these coding change conversions for the last several years and have determined no budget impact was realized. We are making the same estimate of no budget impact for 2012 based on the results of the previous years that we reviewed.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

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	

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

Current Fiscal Year	**Next Fiscal Year**
See # 3 Above	See # 3 Above

Summary for
2012 CPT and HCPCS Procedure Code Conversion

In order to be in compliance with federal regulation 45 CFR Part 45 Section 162.1002; these Notices inform providers of the implementation of the annual Current Procedure Codes (CPT) and the annual Healthcare Common Procedure Codes (HCPCS) systems. These data sets are created and published by the American Medical Association and the Centers for Medicare and Medicaid respectively on an annual basis. This rule is necessary for consistency with the utilization of procedure codes used by Medicare and other third party payers of medical claims; these data sets are standardized and are used nationally for claims processing.

Timeline for 2012 Current Procedure Terminology (CPT) Code and Healthcare Common Procedural Coding System Level II (HCPCS) Conversions

Received to Arkansas Medicaid the 2012 CPT Manual - **10/25/2011**

Received by Provider Reimbursement Unit the electronic copy of 2012 CPT/HCPCs procedure codes from Centers for Medicare and Medicaid (CMS) and sent to fiscal agent - **10/31/2011**

Received notification from fiscal agent that spreadsheet is complete & ready for reviews to begin - **11/8/2012**

Meetings began for review of 2012 **497** new, **106** revised, & **109** deleted procedure codes - **11/15/2011**

Received to Arkansas Medicaid the 2012 HCPCs Manual - **12/29/2011**

Procedure code reviews completed and Statement of Understanding signed for updates/changes to Medicaid Claims Processing system - **02/22/2012**

BCBS 2012 Fee Schedule Received by Provider Reimbursement Unit - **03/06/2012**

AR Medicaid Fee Schedule rates calculated by Provider Reimbursement Unit and sent to fiscal agent - **03/07/2012**

2012 HCPCS Notice of Rule Making completed & submitted to Policy Development /Quality Assurance Unit - **03/20/2012**

2012 CPT Notice of Rule Making completed & submitted to Policy Development /Quality Assurance Unit – **03/21/2012**

2012 CPT/HCPCS Notices of Rule Making signed by Administration - **03/23/2012**

2012 CPT/HCPCS Notices of Rule Making released by Policy Development /Quality Assurance Unit to fiscal agent for printing – **03/23/2012**

Budget Impact requested by Andy Allison for 2012 CPT/HCPCS Conversions - **03/27/2012**

Sign-off of 2012 CPT/HCPCS Conversion CSR - **03/28/2012**

Received directive per Andy Allison/Thomas Carlisle for additional review of budget impact for 2012 CPT/HCPCS Conversions - **03/30/2012**

State notified fiscal agent and & system changes were withdrawn for converting to 2012 CPT/HCPCS procedure codes – **03/30/2012**

State notified fiscal agent to halt mailing of 2012 CPT/HPCS Notices of Rule Making - **03/30/2012**

Budget impact review completed and Administrative approval received to proceed with 2012 CPT/HCPCS conversions – **04/27/2012**

Policy Development /Quality Assurance Unit filed 2 emergency Notices of Rule Making at Capitol re: 2012 CPT/HCPCS conversion implementation– **05/04/2012**

Fiscal agent mailed Notices of Rule Making re: 2012 CPT/HCPCS Conversions to providers – **05/09/2012**

2012 CPT and HCPCS procedure code conversion implemented – **05/11/2012**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

NOTICE OF RULE MAKING

TO: **Health Care Providers – Area Health Education Centers (AHECs), Arkansas Department of Health, Ambulatory Surgical Center, ARKids First-B, Child Health Services (EPSDT), Child Health Management Services (CHMS), Critical Access Hospital, End Stage Renal Disease, Family Planning, Federally Qualified Health Center (FQHC), Hearing, Hospital, Independent Laboratory, Independent Radiology, Oral Surgeons, Physician, Podiatry, Radiation Therapy Center, Rural Health Clinic (RHC) and Vision**

DATE: **May 11, 2012**

SUBJECT: **2012 Current Procedure Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2012 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT® 2012 procedure codes for dates of service on and after May 11, 2012.

Procedure codes that are identified as deletions in CPT® 2012 (Appendix B) are **non-payable** for dates of service on and after May 11, 2012.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid Web site fee schedule will be updated soon after the implementation of the 2012 CPT® and Healthcare Common Procedural Coding System Level II (HCPCS) conversions.

II. Non-Covered 2012 CPT® Procedure Codes

A. Effective for dates of service on and after May 11, 2012, the following CPT® procedure codes are non-covered.

20527	26341	81200	81205	81206	81207
81208	81209	81210	81211	81212	81213
81214	81215	81216	81217	81220	81221
81222	81223	81224	81225	81226	81227
81228	81229	81240	81241	81242	81243
81244	81245	81250	81251	81255	81256
81257	81260	81261	81262	81263	81264
81265	81266	81267	81268	81270	81275

81280	81281	81282	81290	81291	81292
81293	81294	81295	81296	81297	81298
81299	81300	81301	81302	81303	81304
81310	81315	81316	81317	81318	81319
81330	81331	81332	81340	81341	81342
81350	81355	81370	81371	81372	81373
81374	81375	81376	81377	81378	81379
81380	81381	81382	81383	81400	81401
81402	81403	81404	81405	81406	81407
81408	90869	92618			

B. All 2012 CPT® procedure codes listed in **Category II** and **Category III** are not recognized by Arkansas Medicaid; therefore, they are non-covered.

C. The following new 2012 CPT® procedure codes are not payable to Outpatient Hospitals because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code.

15272	15274	15276	15278	15777	22634	32506
32507	32667	32668	32674	64634	64636	94780
94781						

D. The following new 2012 CPT® procedure codes are not payable to Ambulatory Surgical Centers because these services are covered by another CPT® procedure code, another HCPCS code or a revenue code.

15272	15274	15276	15278	15777	22634	32506
32507	32667	32668	32674	64634	64636	94780
94781						

III. 2012 CPT® Procedure Codes with International Classification of Diseases, 9th Revision and Clinical Modification (ICD-9-CM) Diagnosis Restrictions

The following table contains the procedure codes with specific ICD-9-CM diagnosis code restrictions. The following diagnosis protocols are for services rendered based on medical necessity.

Procedure Code	Required Primary (ICD-9-CM) Diagnosis
38232	140.0-208.91
86386	188.0-188.9
87389*	042

*Please refer to Section VI for additional information regarding Family Planning.

IV. Ambulatory Surgical Centers

The following 2012 CPT® procedure codes are payable to Ambulatory Surgical Centers.

15271	15273	15275	15277	22633	29582	29583
29584	32096	32097	32098	32505	32607	32608
32609	32666	32669	32670	33221	33227	33228
33229	33230	33231	33262	33263	33264	36251
36252	36253	36254	37191	37192	37193	49082
49083	49084	62369	62370	64633	64635	74174
77424	77425	78226	78227	78579	78582	78597
78598	87389*+	93998	94726	94727	94728	94729
95885	95886	95887	95938	95939		

*Please refer to Section VI for additional information regarding Family Planning.

+Please refer to Section III for ICD-9-CM diagnosis restriction.

V. Child Health Management Services

The following 2012 CPT® procedure code is payable to Child Health Management Services Providers.

92558

VI. Family Planning

Procedure codes **11975** and **11977** have been replaced with existing 2012 procedure code **11981** and are billable as outlined in the table below. (Existing procedure code 11976 will remain payable for removal, implantable contraceptive capsule).**The following services are not payable to Family Planning only beneficiaries (Aid Category 69).**

For **Professional services**, an ICD-9-CM Family Planning diagnosis code must be billed as **primary on the detail lines.**

Procedure code	Modifier	Provider
11981	FP	Non-hospital based physicians, AHECs Family Planning Clinics and FQHCs
11981	None	Hospital-based physicians
87389	FP	Non-hospital based physicians, Independent Labs, FQHCs, AHECs, and Family Planning Clinics
11981	FP SA	Nurse Practitioners
11981	FP SB	Nurse Midwives

For **Facility Services**, an ICD-9-CM Family Planning diagnosis code must be billed as **primary on the header.**

Procedure code	Modifier	Provider
11981	None	Hospitals and Ambulatory Surgical Centers
87389	None	Hospitals and Ambulatory Surgical Centers

VII. Hearing Services

The following 2012 CPT® procedure code is payable to Hearing Services Providers.

92558

VIII. Independent Radiology

The following 2012 CPT® procedure codes are payable to Independent Radiology Providers.

74174	77424	77425	77469	78226	78227	78579
78582	78597	78598				

IX. Oral Surgeons

The following 2012 CPT® procedure codes are payable to Oral Surgeons.

15275	15276	15277	15278	15777

X. Podiatry Program

The following 2012 CPT® procedure codes are payable to Podiatrists.

15271	15272	15273	15274	15275	15276	15277
15278	15777					

XI. Vision Program

The following 2012 CPT® procedure codes are payable to Vision Services Providers.

92071	92072

XII. Miscellaneous Information

- The following miscellaneous coding changes were implemented for 2012.
  Procedure code **58562** requires paper billing and clinical documentation for justification.
  Procedure code **87902** is payable for AHECs, physicians, independent laboratories, and outpatient hospital providers.

If you have questions regarding this notice, please contact the HP Enterprise Services 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 our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 3-4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals, official notices and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

NOTICE OF RULE MAKING

TO: **Health Care Providers – Area Health Education Centers (AHECs), Ambulatory Surgical Center, Arkansas Department of Health, ARKids First-B, Critical Access Hospital, Home Health, End-Stage Renal Disease, Hospital, Independent Radiology, Physician, Podiatry, Private Duty Nursing, and Prosthetics**

DATE: **May 11, 2012**

SUBJECT: **2012 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion**

I. General Information

A review of the 2012 HCPCS procedure codes has been completed and the Arkansas Medicaid Program will begin accepting updated Healthcare Common Procedural Coding System Level II (HCPCS) procedure codes on claims with dates of service on and after May 11, 2012. Drug procedure codes require National Drug Code (NDC) billing protocol. Drug procedure codes that represent radiopharmaceuticals, vaccines, and allergen immunotherapy are exempt from the NDC billing protocol.

Procedure codes that are identified as deletions in 2012 HCPCS Level II will become non-payable for dates of service on and after May 11, 2012.

Please note: The Arkansas Medicaid website fee schedule will be updated soon after the implementation of the 2012 CPT and HCPCS conversions.

II. 2012 HCPCS Payable Procedure Codes Tables Information

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

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

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

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

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

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

4. Certain procedure codes are covered only when the primary diagnosis is covered within a specific ICD-9-CM diagnosis range. This information is used, for example, by physicians and hospitals. The fourth column, for all affected programs, indicates the beginning and ending range of ICD-9-CM diagnoses for which a procedure code may be used, (i.e., 053.0 through 054.9).

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

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

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

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

B. Acquisition of Prior Approval Letter:

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

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

2. The Medical Director for Clinical Affairs' review is necessary to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.
   a. The provider must submit a history and physical examination with the treatment plan before beginning any treatment.
   b. The provider will be notified by mail of the DMS Medical Director for Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a prior approval letter is issued and must be attached to each paper claim submission.

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

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

Mailing address: Attention: Medical Director for Clinical Affairs Division of Medical Services AR Department of Human Services P.O. Box 1437, Slot S412 Little Rock, AR 72203-1437	Fax: 501-682-8013 Phone: 501-682-9868

C. Process for Obtaining Prior Authorization:

1. When obtaining a prior authorization from the Arkansas Medicaid Utilization Review Section, please send your request to the following:

Telephone Toll free	1-800-482-5850, extension 2-8340
Telephone	(501) 682-8340
Fax	(501) 682-8013
Mailing address	Arkansas DHS Division of Medical Services Utilization Review Section P.O. Box 1437, Slot S413 Little Rock, AR 72203-1437

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

In-state and out-of-state toll free for inpatient reviews, prior authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax	(479) 649-0799
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	1000 Fianna Way Fort Smith, AR 72919-9008
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

III. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. Diagnosis list 003 is specified below. For any other diagnosis restrictions, reference the table for each individual program.

Diagnosis List 003

042
140.0-209.36
209.70 through 209.75
209.79
230.0 through 238.9
511.81
V58.11 through V58.12
V87.41

IV. HCPCS Procedure Codes Payable to Ambulatory Surgical Centers (ASC)

The following information is related to procedure codes payable to ASC providers.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q4124	No	No	No	No	No	No	No

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

The following information is related to procedure codes payable to End-Stage Renal Disease Providers.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J8561	No	18y & up	996.81	No	No	No	No

VI. HCPCS Procedure Codes Payable to Home Health Providers

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

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A5056	No	No	No	No	No	No	No
A5057	No	No	No	No	No	No	No

VII. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers. Claims that require attachments (such as op-reports and prior approval letters) must be billed on a paper claim. See Section II of this notice for information on requesting a prior approval letter. See Section III of this notice for ICD-9-CM diagnosis codes contained in diagnosis list 003.

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

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9585	No	2y & up	No	No	No	No	No
C9286	No	18y & up	V42.0	No	No	No	No
C9287*	No	18y & up	200.6 or 201.9	No	Yes	No	Yes

This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. Prior approval letter requests should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. The discussion of risk of PML should be documented in medical records.

J0257	No	18y & up	273.4	No	No	No	No

This drug or other drugs in this class are only approved for the diagnosis of alpha1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha1-proteinase must be clearly documented in the chart. Alpha1 antitrypsin concentrations should be less than 80 mg. per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
	emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of therapy should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to Alpha1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency associated liver disease without emphysema, cystic fibrosis, and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha1 antitrypsin levels above 80 mg/dl. Due to the risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.						
J0490*	**No**	**18y & up**	**695.4**	**No**	**Yes**	**No**	**Yes**
	This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis, or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.						
J0588	**No**	**18y & up**	**No**	**No**	**Yes**	**No**	**No**
	An ICD-9-CM diagnosis code which supports medical necessity is required.						
J0712	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
J0897*	**No**	**18y & up**	**Yes** See below.	**No**	**Yes**	**No**	**Yes**
	Prolia Policy: Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis (ICD-9-CM 733.1). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high-risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for Prolia. An additional indication approved by the FDA for use of Prolia as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (ICD-9-CM 185) or adjuvant aromatase inhibitor therapy for breast cancer (ICD-9-CM 174.0-175.9). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request.						

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
	Xgeva Policy: Arkansas Medicaid requires that Xgeva be filed under J0897 on a paper claim with the drug name and dose. Xgeva is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. Xgeva is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. Xgeva requires documentation in the medical record of the rationale for why Zometa was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record. The NDC for the drug requested must be listed on the request.						
J1557	**No**	**2y & up**	**No**	**No**	**Yes**	**No**	**No**
	An ICD-9-CM diagnosis code that supports medical necessity in required.						
J2507*	**No**	**18y & up**	**274.00 - 274.03**	**No**	**Yes**	**No**	**Yes**
	The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.						
J7180	**No**	**2y & up**	**286.3**	**No**	**No**	**No**	**No**
J7183	**No**	**No**	**286.4**	**No**	**No**	**No**	**No**
J8561	**No**	**18y & up**	**996.81**	**No**	**No**	**No**	**No**
J9043*	**No**	**18y & up**	**185**	**No**	**Yes**	**No**	**Yes**
	This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.						
J9179*	**No**	**18y & up**	**174.0 - 175.9**	**No**	**Yes**	**No**	**Yes**
	This procedure code is only approved for treatment of metastatic breast cancer in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well versed in the use of chemotherapy and treatment of any side effects.						
J9228*	**No**	**18y & up**	**172.0 - 172.9**	**No**	**Yes**	**No**	**Yes**
	Ipilmumab is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic						

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
	test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin, or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.						
Q0162	**UB**	**4y & up**	**No**	**No**	**No**	**No**	**No**
	Q0162-UB represents "Ondansetron 1 mg., oral" billable electronically or on paper.						
Q2043*	**No**	**18y & up**	**185**	**No**	**Yes**	**No**	**Yes**
	This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at two-week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread, or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medications with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed medical history and physical exam is required for approval.						
Q4124	**No**	**No**	**No**	**No**	**No**	**No**	**No**
S0119	**No**	**4y & up**	**No**	**No**	**No**	**No**	**No**
J3490	**U9**	**16y & up**	**V23.41**	**No**	**No**	**No**	**No**
	Arkansas Medicaid will reimburse providers for "**Compounded 17-Hydroxy-progesterone Caproate, 250 mg.**" **per day** under **J3490-U9.** It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate, 250 mg.", may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code of V23.41, "Pregnancy with history of pre-term labor". J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hhydroxyprogesterone Caproate, 250 mg" is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg".						

Miscellaneous Information

HCPCS Procedure Code **J0895** has no restrictions. **J0256** is restricted to ICD-9-CM diagnosis code **273.4**.

VIII. HCPCS Procedure Codes Payable to Physicians and Area Health Care Education Centers (AHECs)

The following information is related to procedure codes payable to Physicians and AHECs. Claims that require attachments (such as operative reports and prior approval letters) must be billed on a paper claim. See Section II of this notice for information on requesting a prior approval letter. See Section III of this notice for using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes contained in diagnosis list 003.

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

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A9585	No	2y & up	No	No	No	No	No
C9286	No	18y & up	V42.0	No	No	No	No
C9287*	No	18y & up	200.6 or 201.9	No	Yes	No	Yes

This procedure code is indicated for the treatment of adults with Hodgkin's lymphoma, after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates. It is also indicated for patients with systemic anaplastic large cell lymphoma, after failure of at least one prior multi-agent chemotherapy regimen. The prior approval letter request should include current history and physical exam to demonstrate that beneficiaries meet criteria. All previous chemotherapy regimens should be well-documented in records submitted. Reasons why patient is not an ASCT candidate should be clearly documented. A treatment cycle maximum of 16 cycles will only be approved. Infusions should only be done in centers with knowledgeable physicians readily available to treat infusion reactions. Patients should be closely monitored for evidence of Progressive Multifocal Leukoencephalopathy (PML) and should be counseled on signs and symptoms. Discussion of risk of PML should be documented in medical records.

J0257	No	18y & up	273.4	No	No	No	No

This drug or other drugs in this class are only approved for the diagnosis of alpha1-proteinase (antitrypsin) deficiency with clinically evident emphysema. Levels of alpha1-proteinase must be clearly documented in the chart. Alpha1 antitrypsin concentrations should be less than 80 mg per deciliter (mg/dl). The medical record should contain a history and physical exam documenting this disease with clear clinical evidence of emphysema. Obstructive lung disease, emphysema, is defined by a forced expiratory volume in one second (FEV1) of 30-65% of predicted or a rapid decline in lung function as defined as a change in FEV1 of greater than 120 ml/year. The patient should be a nonsmoker. The dosage, frequency, site of administration and duration of therapy should be reasonable, clinically appropriate and supported by evidence-based literature and adjusted based upon severity, alternative available treatments and previous response to Alpha1 Proteinase Inhibitor (Human) therapy for the condition addressed. Coverage for deficiency associated liver disease without emphysema, cystic fibrosis and diabetes mellitus is considered experimental and is not approved. Therapy should maintain alpha1 antitrypsin levels above 80 mg/dl. Due to the risk of anaphylaxis, this drug must be given in an infusion center with immediate access to a physician trained in the treatment of this reaction. The only other approved infusion would be by a specially

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
	trained nurse who has immediate access to treatment for anaphylaxis and is trained in this special situation.						
J0490*	**No**	**18y & up**	**695.4**	**No**	**Yes**	**No**	**Yes**
	This drug is indicated for treatment of patients age 18 years and above with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy, such as non-steroidal anti-inflammatory drugs, hydroxychloroquine, corticosteroids or immunosuppressive drugs. Use of this drug is not recommended for use in combination with other biologics or intravenous cyclophosphamide, or patients with severe active lupus nephritis or severe active central nervous system lupus. This drug administration requires a prior approval letter which must include a history and physical exam documenting all prior treatment and documented failure of treatment. The patient should continue to receive the standard therapy. This drug should be administered by healthcare providers prepared to manage anaphylaxis and must be prescribed by a rheumatologist.						
J0588	**No**	**18y & up**	**No**	**No**	**Yes**	**No**	**No**
	An ICD-9-CM diagnosis code which supports medical necessity is required.						
J0712	**No**	**18y & up**	**No**	**No**	**No**	**No**	**No**
J0897*	**No**	**18y & up**	**Yes** See below.	**No**	**Yes**	**No**	**Yes**
	Prolia Policy: Covered for female, post menopausal beneficiaries with osteoporosis and inability to tolerate oral medications for osteoporosis, (ICD-9-CM 733.1). Inability to tolerate oral medications must be documented in medical history and physical exam with reason for intolerance clearly documented and name of oral medications that patient was unable to tolerate. Inability to tolerate oral medication must include signs and symptoms of esophageal disease. Patient must be at high-risk for osteoporotic fracture or have multiple risk factors for fracture. Physicians should document that they have informed the patient of the risks of therapy in accordance with the Food and Drug Administration (FDA) Risk Evaluation and Mitigation Strategy Program. Use this procedure code for Prolia. Additional indication approved by the FDA for use of Prolia as treatment to increase bone mass in patients at high-risk for fracture receiving androgen deprivation therapy for non-metastatic prostate cancer (ICD-9-CM 185) or adjuvant aromatase inhibitor therapy for breast cancer (ICD-9-CM 174.0-175.9). In men with non-metastatic prostate cancer, Denosumab also reduced the incidence of vertebral fracture. Medical records must include history and physical exam clearly documenting above indications and why Zometa cannot be used. The NDC for the drug requested must be listed on the request. **Xgeva Policy:** Arkansas Medicaid requires that Xgeva be filed under J0897 on a paper claim with the drug name and dose. Xgeva is only approved for prevention of skeletal-related events in patients with bone metastases from breast and prostate cancer and solid tumors. Xgeva is not indicated for the prevention of skeletal-related events in patients with multiple myeloma. Xgeva requires documentation in the medical record of the rationale for why Zometa was not used. A complete history and physical exam documenting the type of cancer and what chemotherapy is prescribed is required to be in the medical record. The NDC for the drug requested must be listed on the request.						
J1557	**No**	**2y & up**	**No**	**No**	**Yes**	**No**	**No**
	An ICD-9-CM diagnosis code that supports medical necessity in required.						

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J2507*	No	18y & up	274.00 - 274.3	No	Yes	No	Yes
	The submitted medical documentation should include a history and physical exam that demonstrates that the beneficiary has failed all other treatments for gout due to progression of disease or intolerable side effects. This drug should only be administered in health care settings and by physicians prepared to manage anaphylaxis and infusion reactions. Premedication should be administered, and the patient should be watched for any reaction after infusion. It is not recommended for the treatment of asymptomatic gout.						
J7180	No	2y & up	286.3	No	No	No	No
J7183	No	No	286.4	No	No	No	No
J8561	No	18y & up	996.81	No	No	No	No
J9043*	No	18y & up	185	No	Yes	No	Yes
	This drug is indicated to be used in combination with prednisone for treatment of patients with hormone-refractory metastatic prostate cancer previously treated with decetaxel-containing treatment regimen. This must be well documented in a history and physical exam submitted for prior approval letter. Failure of previous chemotherapy must be well documented. Physicians must be able to manage hypersensitivity reactions appropriately in the setting of the infusion.						
J9179*	No	18y & up	174.0 – 175.9	No	Yes	No	Yes
	This procedure code is only approved for treatment of metastatic breast cancer, in patients who have previously received at least two chemotherapy regimens for the treatment of metastatic disease. Prior therapy should have included an anthracycline and a taxane in either the adjuvant or metastatic setting. A complete history and physical exam is required documenting all prior treatments and the failure of therapy. This drug should only be given by physicians who are well-versed in the use of chemotherapy and treatment of any side effects.						
J9228*	No	18y & up	172.0 – 172.9	No	Yes	No	Yes
	Ipilmumab is indicated for the treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function tests, and clinical chemistries must be monitored before each dose. The genetic test for BRAF V600E mutation should be done on all patients to determine whether they are candidates for Zelboraf. If positive for the mutation, the patient should first be given a trial of Zelboraf. If the patient fails the trial or does not have the mutation, then they should be considered for Ipilmumab. Ipilmumab should only be prescribed by physicians who are prepared to treat immune mediated complications. Participation in the risk evaluation and mitigation program is essential. Use of Ipilmumab requires a detailed history and physical exam including all previous treatments and clear documentation that the melanoma is not treatable by surgery or has metastasized. Patients considered for treatment with Ipilmumab should be at least 18 years old and have a life expectancy of at least 4 months and have previously been treated with either dacarbazine, temozolomide, carboplatin, or interleukin-2. If not treated first with one of these drugs, a detailed letter of medical necessity documenting the reasons for not treating the patient with one of these drugs first is required.						

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q0162	**UB**	**4y & up**	**No**	**No**	**No**	**No**	**No**
Q0162-UB represents "Ondansetron 1 mg., oral", billable electronically or on paper.							
Q2043*	**No**	**18y & up**	**185**	**No**	**Yes**	**No**	**Yes**
This drug is indicated for the treatment of asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) prostate cancer. Only three doses administered at 2 week intervals will be approved. There must be clear documentation of use of hormone treatment and documentation of no response by Prostate Specific Antigen levels, abnormal radiology studies showing spread or some other method of determining metastatic disease. Concomitant use of chemotherapy or immunosuppressive medications with this drug has not been studied. This drug will only be approved for centers that have the ability to perform leukapheresis. A detailed, medical history, and physical exam is required for approval.							
Q4124	**No**	**No**	**No**	**No**	**No**	**No**	**No**
S0119	**No**	**4y & up**	**No**	**No**	**No**	**No**	**No**
J3490	**U9**	**16y & up**	**V23.41**	**No**	**No**	**No**	**No**
Arkansas Medicaid will reimburse providers for "**Compounded 17-Hydroxy-progesterone Caproate, 250 mg per day**" under **J3490-U9**. It will be covered for females, ages 16 years and above, when a singleton pregnancy exists and a history of pre-term labor is present. "Compounded 17-Hydroxyprogesterone Caproate, 250 mg.", may be administered every 7 days, with treatment initiated between 16 weeks, 0 days, and 20 weeks, 6 days, and continued until week 37 for delivery. J3490-U9 may be billed electronically or on a paper claim (CMS-1500 or CMS-1450), with a primary ICD-9-CM diagnosis code V23.41, "Pregnancy with history of pre-term labor." J3490-U9 is exempt from NDC billing protocol. The administration fee for "Compounded 17-Hydroxyprogesterone Caproate, 250 mg." is included in the reimbursement fee allowed for this drug. The U9 modifier must always accompany this procedure code when referring to "Compounded 17-Hydroxyprogesterone Caproate 250 mg."							

Miscellaneous Information

HCPCS Procedure Code **J0895** has no restrictions. **J0256** is restricted to ICD-9-CM diagnosis code **273.4.**

Effective on or after May 11, 2012, the following existing HCPCS procedure codes will be billable electronically or on paper.

L8615	L8616	L8617	L8618	L8619
L8623	L8627	L8628	L8629	V5273

IX. HCPCS Procedure Codes Payable to Podiatry

The following information is related to procedure codes payable to Podiatry providers.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
Q4124	No	No	No	No	No	No	No

X. HCPCS Procedure Codes Payable to Private Duty Nursing

The following information is related to procedure codes payable to Private Duty Nursing Providers.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A5056	No	No	No	No	No	No	No
A5057	No	No	No	No	No	No	No

XI. HCPCS Procedure Codes Payable to Prosthetics

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

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

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A5056	No	No	No	No	No	No	No
A5057	No	No	No	No	No	No	No
E0988	NU	21y & up	No	No	No	Yes	No
E0988	EP	2y-20y	No	No	No	Yes	No
E2359	NU	21y & up	No	No	No	No	No
E2359	EP	2y-20y	No	No	No	No	No
E2626	NU	21y & up	No	No	No	Yes	No
E2626	EP	2y-20y	No	No	No	Yes	No
E2627	NU	21y & up	No	No	No	Yes	No
E2627	EP	2y-20y	No	No	No	Yes	No

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
E2628	NU	21y & up	No	No	No	Yes	No
E2628	EP	2y-20y	No	No	No	Yes	No
E2629	NU	21y & up	No	No	No	Yes	No
E2629	EP	2y-20y	No	No	No	Yes	No
E2630	NU	21y & up	No	No	No	Yes	No
E2630	EP	2y-20y	No	No	No	Yes	No
E2631	NU	21y & up	No	No	No	Yes	No
E2631	EP	2y-20y	No	No	No	Yes	No
E2632	NU	21y & up	No	No	No	Yes	No
E2632	EP	2y-20y	No	No	No	Yes	No
E2633	NU	21y & up	No	No	No	Yes	No
E2633	EP	2y-20y	No	No	No	Yes	No
L5312	NU	21y & up	No	No	No	Yes	No
L5312	EP	0-20y	No	No	No	Yes	No
L6880	NU	21y & up	No	No	No	Yes	No
L6880	EP	0-20y	No	No	No	Yes	No

The following miscellaneous coding changes were implemented for 2012 effective May 11, 2012.

Procedure code **A7034** will no longer be payable; see table below for replacement code **E0601**.

HCPCS Procedure Codes **E2402** and **E0637** are payable as indicated in the table below.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
E2402	NU	21y & up	No	No	No	Yes	No
E2402	EP	2y-20y	No	No	No	Yes	No
E0637	NU	21y & up	No	No	No	Yes	No
E0637	EP	2y-20y	No	No	No	Yes	No
E0601	NU RR	No	No	No	No	Yes	No

⁂(CPAP Device Nasal Continuous Positive Airway Pressure (CPAP) Device; includes necessary accessory items) NOTE: Complete medical data pertinent to the request must be submitted with the prior authorization request. Bill **E0601** as the global daily rental service. Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap.

Procedure Codes	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
E0601	No	No	No	No	No	Yes	No
⁂(CPAP Device Nasal Continuous Positive Airway Pressure (CPAP) Device; includes necessary accessory items. NOTE: For 21+, complete medical data pertinent to the request must be submitted with the prior authorization request. Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap.							

Effective on or after May 11, 2012 the following existing HCPCS procedure codes will be billable electronically or on paper.

L8615	L8616	L8617	L8618	L8619
L8623	L8627	L8628	L8629	V5273

XII. Non-Covered 2012 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2012 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code, or a revenue code.

A9272	C1830	C1840	C1886	C9732
G0448	G9156	J7665	K0741	Q4122
Q4128				

XIII. Non-Covered 2012 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A9584	C9285	C9366	E2358	G0442	G0443	G0444	G0445
G0446	G0447	G0449	G0450	G0451	G0908	G0909	G0910
G0911	G0912	G0913	G0914	G0915	G0916	G0917	G0918
G0819	GO920	GO921	GO922	G8694	G8695	G8696	G8697
G8698	G8699	G8700	G8701	G8702	G8703	G8704	G8705
G8706	G8707	G8708	G8709	G8710	G8711	G8712	G8713
G8714	G8715	G8716	G8717	G8718	G8720	G8721	G8722
G8723	G8724	G8725	G8726	G8727	G8728	G8730	G8731
G8732	G8733	G8734	G8735	G8736	G8737	G8738	G8739
G8740	G8741	G8742	G8743	G8744	G8745	G8746	G8747
G8748	G8749	G8750	G8751	G8752	G8753	G8754	G8755
G8756	G8757	G8758	G8759	G8760	G8761	G8762	G8763

G8764	G8765	G8767	G8768	G8769	G8770	G8771	G8772
G8773	G8774	G8775	G8776	G8777	G8778	G8779	G8780
G8781	G8782	G8783	G8784	G8785	G8786	G8787	G8788
G8789	G8790	G8791	G8792	G8793	G8794	G8795	G8796
G8797	G8798	G8799	G8800	G8801	G8802	G8803	G8805
G8806	G8807	G8808	G8809	G8810	G8811	G8812	G8813
G8814	G8815	G8816	G8817	G8818	G8819	G8820	G8821
G8822	G8823	G8824	G8825	G8826	G8827	G8828	G8829
G8830	G8831	G8832	G8833	G8834	G8835	G8836	G8837
G8838	G8839	G8840	G8841	G8842	G8843	G8844	G8845
G8846	G8847	G8848	G8849	G8850	G8851	G8852	G8853
G8854	G8855	G8856	G8857	G8858	G8859	G8860	G8861
G8862	G8863	G8864	G8865	G8866	G8867	G8868	G8869
G8870	G8871	G8872	G8873	G8874	G8875	G8876	G8877
G8878	G8879	G8880	G8881	G8882	G8883	G8884	G8885
G8886	G8887	G8888	G8889	G8890	G8891	G8892	G8893
G8894	G8895	G8896	G8897	G8898	G8899	G8900	G8901
G8902	G8903	G8904	G8905	G8906	J0131	J0221	J0840
J1725	J2265	J7131	J7326	K0742	K0743	K0744	K0745
K0746	L6715	Q0162	Q4123	Q4125	Q4126	Q4127	Q4129
Q4130	S3722	S8130	S8131				

If you have questions regarding this notice, please contact the HP Enterprise Services 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 our Americans with Disabilities Act Coordinator at 501-683-4120 (Local); 1-800-482-5850, extension 3-4120 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals, official notices and remittance advice (RA) messages are available for download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director