TOC not required

242.120 Enteral (Sole Source) Formulae ~~2~~12-1-~~20~~17

The following pages provide the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

Modifiers in this section are indicated by the headings M1, M2, and M3.

Enteral formulae are divided into several categories. Each unit of service equals one-hundred (100) calories of formula. All supplies and equipment necessary to administer the nutrients in the beneficiary's place of residence, except the infusion pump and pump supply kit, are included in the unit description.

~~For a non-covered prescribed formula, a review for medical necessity will be performed upon request. The product information, with assigned HCPCS code and physician documentation of the medical necessity of the formula for a specific beneficiary, must be submitted to Utilization Review.~~ **~~View or print the Utilization Review Section contact information.~~** ~~If approved, the formula will be added to the list of covered formulae and the Provider will be notified. If denied, the Provider and beneficiary will be notified.~~

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preference for formulae will not be considered for medical necessity.

A separate prior authorization must be obtained for the enteral infusion pump and the pump supply kit. The enteral infusion pump and the pump supply kit may be billed separately.

Exceptions to Use of Formula

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk ~~and/~~or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk ~~and/~~or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk ~~and/~~or soy protein; chronic diarrhea, short gut; cystic fibrosis, fat malabsorption due to GI, or liver disease.

D. Gerber Extensive HA – Allergy to milk ~~and/~~or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome, known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24 – Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

NOTE: ~~WIC (Women Infants Children Program)~~The Women, Infant, and Children program (WIC) must be accessed before the Medicaid Program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC program in Arkansas. Changes will be reflected in the appropriate Medicaid ~~P~~provider manual.

~~** These covered formulae are substitutions for PediaSure.~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4149	U9			Enteral formula, blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Compleat~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4150	U9			Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
~~**Covered Formulae:**~~ ~~Boost~~ ~~Carnation Instant Breakfast – PregLactose Free~~ ~~Ensure~~ ~~Ensure Fiber with FOS~~ ~~Ensure High Protein~~ ~~Ensure Powder~~				~~Fibersource HN~~ ~~IsoSource HN~~ ~~Jevity 1.0 CAL~~ ~~Nutren 1.0~~	~~Nutren Junior 1.0 Fiber~~ ~~Osmolite 1.0 CAL~~ ~~Promote~~ ~~Promote with Fiber~~
B4152	U9			Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml), with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Plus~~ ~~Carnation Instant Breakfast – Lactose Free Plus~~ ~~Ensure Plus~~ ~~Nutren Junior 1.5~~ ~~Nutren Junior 2.0~~ ~~Osmolite 1.5 Cal~~ ~~Resource 2.0~~ ~~Scandishake~~ ~~Two-Cal HN~~
B4153	U9			Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Peptamen~~ ~~Peptamen 1.5~~ ~~Peptamen with Prebio 1~~ ~~Perative~~ ~~Tolerex~~ ~~Vital HN~~ ~~Vivonex Plus~~ ~~Vivonex TEN~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4154	U9			Enteral formula, nutritionally complete, for special metabolic needs, includes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, ~~and/~~or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
				~~Impact with Fiber~~ ~~Ketocal 4:1~~ ~~Ketocal 3:1~~ ~~Nepro with Carb~~ ~~NutriHep~~	~~Pulmocare~~ ~~Similac PM 60/40~~ ~~Suplena with Carb Steady~~
B4155 Bill on Paper (Indicate specific name of formula on claims.)	U9			Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin
B4155	U9	U1		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Polycose Powder Scandical

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4155	U9	U2		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Microlipid
B4155	U9	U3		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	~~MSUD 1~~ ~~MSUD 2~~ ~~Periflex Infant~~ ~~Periflex Junior Plus~~ ~~RCF~~ ~~TYR1~~ ~~TYR 2~~
B4158	U9			Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Portagen~~ ~~Similac Advance~~ ~~Similac Advance~~
B4159	U9			Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Similac Soy Isomil~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4159 (Ages 0-4 Years)	U9	U8		Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Similac Advance (20 calorie – milk-based)~~ ~~Similac Soy Isomil (20 calorie) – soy based~~
B4160	U9			Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Kids Essentials~~ ~~Nutren Junior with Fiber~~ ~~Nutren Junior~~
B4160 (Ages 0-4 Years)	U9	U8		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Kids Essentials~~ ~~Nutren Junior~~ ~~Nutren Junior with Fiber~~
B4160	U9	U1		Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Gerber Good Start Premature 24~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4160 (Ages 0-4 Years)	U9	U1	U8	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~EnfaCare~~
B4161	U9			Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Alfamino Infant~~ ~~Alfamino Junior~~ ~~Nutramigen Enflora LGG~~ ~~Nutramigen LIPIL~~ ~~Pregestimil~~ ~~Gerber Extensive HA~~
B4161 Ages 5 to 99 Years B4161 (Ages 0-4 Years)	U9 U9	 U8		Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Neocate Splash~~ ~~Peptamen Junior~~ ~~Vivonex Pediatric~~
B4162	U9			Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
~~**Covered Formulae:**~~ ~~Calcilo XD~~ ~~Cyclinex-1~~ ~~Cyclinex-2~~ ~~Glutarex-1~~ ~~Glutarex-2~~ ~~Hominex-1~~ ~~Hominex-2~~ ~~I Valex-1~~ ~~I Valex-2~~ ~~Ketonex-1~~ ~~Ketonex-2~~				~~MSUD Maxamaid~~ ~~MSUD Maxamum~~ ~~MSUD Analog~~ ~~Periflex Infant~~ ~~Periflex Junior Plus~~ ~~Phenex-1~~	~~Phenex-2~~ ~~Propimex-1~~ ~~Propimex-2~~ ~~XLys, XTrp Maxamaid~~ ~~Xphe Maxamaid~~ ~~Xphe Maxamum~~ ~~XPhe, XTyr Analog~~ ~~XPhe, XTyr Maxamaid~~

HCPCS Code	M1	M2	M3	Description	Covered Formulae
B4162	U9	U1		Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~XMTVI Maxamaid~~

TOC required

212.209 (DME) ~~MIC-KEY~~Low-Profile Skin Level Gastrostomy Tube (~~MIC-KEY~~Low-Profile Button) and Supplies for Beneficiaries of All Ages

~~7~~12-1-~~14~~20

The Arkansas Medicaid Program reimburses for the ~~MIC-KEY~~Low-Profile Skin Level Gastrostomy Tube (~~MIC-KEY~~Low-Profile ~~button~~Button) and supplies for Medicaid-eligible beneficiaries of all ages. Prior authorization (PA) from ~~AFMC~~ DHS or its designated vendor is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be completed and sent, along with sufficient medical documentation. **View or print contact information for how to submit the request.** ~~to AFMC.~~

Field Code Changed

The ~~MIC-KEY~~Low-Profile Kit is benefit-limited to two (2) per state fiscal year (SFY). The accessories, extension sets, and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary. ~~Prior authorization must be obtained from AFMC for any extensions using form DMS-679A.~~ **View or print AFMC contact information.** **View or print form DMS-679A and instructions for completion.**

Field Code Changed

Field Code Changed

212.210 DME ~~MIC-KEY~~Low-Profile Percutaneous Cecostomy Tube (~~MIC-KEY~~Low-Profile ~~button~~Button) for Beneficiaries of All Ages

~~10~~12-1-~~15~~20

~~The Arkansas Medicaid Program reimburses for the MIC-KEY Percutaneous Cecostomy Tube (MIC-KEY button) for Medicaid-eligible beneficiaries of all ages. Arkansas Medicaid will reimburse the MIC-KEY Skin Level Gastrostomy Tube for all ages, when used for the management of severe fecal incontinence (see diagnosis codes below) requiring percutaneous cecostomy tube placement for bowel evacuation. Prior authorization (PA) from AFMC is required.~~

~~When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components*, must be completed and sent, along with sufficient medical documentation, to AFMC.~~ **View or print AFMC contact information.** **View or print form DMS-679A and instructions for completion.**

Field Code Changed

Field Code Changed

~~The MIC-KEY button is benefit-limited to 2 per state fiscal year (SFY).~~

The ~~MIC-KEY~~Low-Profile ~~b~~Button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes. **(View ICD codes.)**

Field Code Changed

The ~~MIC-KEY~~Low-Profile ~~b~~Button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

44300	49442	49450

242.150 Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age

~~11~~12-1-~~17~~20

The following list provides the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

The coverage listed is payable only if the service is prescribed as a result of a Child Health Services (EPSDT) screening/referral.

~~There is n~~No prior authorization is required for nutritional formulae for EPSDT beneficiaries from age five (5) years through twenty (20) years.

Prior authorization is required for beneficiaries from birth through four (4) years. Use of modifier **U7** in the following list will be necessary, as indicated.

To request prior authorization, providers should complete the ~~Arkansas Foundation for Medical Care, Inc.~~ *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (DMS-679A), attaching a copy of the EPSDT screening/referral as well as a prescription signed by the beneficiary's PCP. **View or print form DMS-679A. View or print contact information for how to submit the request.**

Field Code Changed

Field Code Changed

NOTE: The Women, Infant, and Children program (WIC) must be accessed ~~first~~ before the Medicaid program for children from birth to ~~their fifth birthday~~five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC Program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preferences for formulae will not be considered for medical necessity.

Exceptions to Use of Formulae

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk ~~and/~~or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk ~~and/~~or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk ~~and/~~or soy protein; chronic diarrhea, short gut; cystic fibrosis; fat malabsorption due to GI or liver disease.

D. Gerber Extensive HA – Allergy to milk ~~and/~~or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome; known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen, or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24– Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. Modifier **BO** is used to bill for oral usage. When a second or third modifier is listed, that modifier must be used in conjunction with **EP**.

For beneficiaries from birth through four (4) years of age, the use of modifier **U7,** as well as additional documentation will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

Modifiers in this section are indicated by the headings M1, M2, M3 and M4.

~~** These covered formulae are substitutions for PediaSure.~~

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4149	EP				Enteral formula, blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Compleat~~
B4149	EP	BO				
B4149	EP	U7				
B4149	EP	U7	BO			
Ages 0 – 4 Years requires PA						
B4150	EP				Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
B4150	EP	BO				
B4150	EP	U7				
B4150	EP	U7	BO			
Ages 0 – 4 Years requires PA						

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
~~Covered Formulae:~~ ~~Boost~~ ~~Carnation Instant Breakfast – Lactose Free~~ ~~Ensure~~ ~~Ensure Fiber with FOS~~ ~~Ensure High Protein~~ ~~Ensure Powder~~					~~Fibersource HN~~ ~~IsoSource HN~~ ~~Jevity 1.0 CAL~~ ~~Nutren 1.0~~	~~Nutren Junior 1.0~~ ~~Fiber~~ ~~Osmolite 1.0 CAL~~ ~~Promote~~ ~~Promote with Fiber~~
B4150	EP	U1	BO		Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Pudding~~ ~~Ensure Pudding~~
B4150 Ages 0 – 4 Years requires PA	EP	U1	U7	BO		
B4152	EP				Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 Kcal/ml), with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Plus~~ ~~Carnation Instant Breakfast – Lactose Free Plus~~ ~~Ensure Plus~~ ~~Nutren Junior 1.5~~ ~~Nutren Junior 2.0~~ ~~Osmolite 1.5 Cal~~ ~~Resource 2.0~~ ~~Scandishake~~ ~~Two Cal HN~~
B4152	EP	BO				
B4152	EP	U7				
B4152 Ages 0 – 4 Years requires PA	EP	U7	BO			
B4153	EP				Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Peptamen~~ ~~Peptamen 1.5~~ ~~Peptamen with Prebio 1~~ ~~Perative~~ ~~Tolerex~~ ~~Vital HN~~ ~~Vivonex Plus~~ ~~Vivonex TEN~~
B4153	EP	BO				
B4153	EP	U7				
B4153 Ages 0 – 4 Years requires PA	EP	U7	BO			

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4154 B4154 B4154 B4154 Ages 0 – 4 Years requires PA	EP EP	 BO			Enteral formula, nutritionally complete, for special metabolic needs, includes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins, ~~and/~~or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
~~**Covered formulae:**~~ ~~Boost Glucose Control~~ ~~Glucerna 1.0 cal~~ ~~Nutren Glytrol~~ ~~Hepatic Aid II~~ ~~Impact~~					~~Impact with Fiber~~ ~~Ketocal 4:1~~ ~~Ketocal 3:1~~ ~~Nepro with Carb Steady~~ ~~NutriHep~~	~~Pulmocare~~ ~~Similac PM 60/40~~ ~~Suplena with Carb Steady~~
B4155 B4155 Bill on paper (Indicate specific name of formula on claims.)	EP EP	 BO			Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin
B4155 B4155 Ages 0 – 4 Years requires PA Bill on paper (Indicate specific name of formula on claims.)	EP EP	 U7	 BO		Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	MCT Oil Procel Protein Supplement Provimin

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP EP EP	U1 U1 U1 U1	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	SolCarb Scandical
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP EP EP	U2 U2 U2 U2	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	Microlipid
B4155 B4155 B4155 B4155 Ages 0 – 4 Years requires PA	EP EP EP EP	U3 U3 U3 U3	 BO U7 U7	 BO	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arganine), fat (e.g., medium chain triglycerides), or combination, administered through an enteral feeding tube, 100 calories = 1 unit	~~MSUD 1~~ ~~MSUD 2~~ ~~Periflex Infant~~ ~~Periflex Junior Plus~~ ~~RCF~~ ~~TYR 1~~ ~~TYR 2~~

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4158 B4158 B4158 B4158 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO	 	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Portagen~~ ~~Similac Advance~~ ~~Similac Advance~~
B4159 B4159 B4159 B4159 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO	 	Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Similac Soy Isomil~~
B4159 B4159 B4159 B4159 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U8 U8	 U7 U7	 BO	Enteral formula, for pediatrics, nutritionally complete soy base with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, ~~and/~~or iron, administered through an enteral feeding tube, 100 calories = 1 unit	~~Similac Advance (20 calorie – milk based)~~ ~~Similac Soy Isomil (20 calorie – soy based)~~
B4160 B4160 B4160 B4160 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO	 	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Kids Essentials~~ ~~Nutren Junior~~ ~~Nutren Junior with Fiber~~

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4160 B4160 B4160 B4160 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U8 U8	 U7 U7	 BO	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Boost Kids Essentials~~ ~~Nutren Junior~~ ~~Nutren Junior with Fiber~~
B4160 B4160 B4160 B4160 Ages 0 – 4 Years requires PA	EP EP EP EP	U1 U1 U1 U1	 BO U7 U7	 BO	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Gerber Good Start Premature 24~~
B4160 B4160 Ages 0 – 4 Years requires PA	EP EP	U1 U1	U8 U8	 BO	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Enfamil EnfaCare~~
B4161 B4161 B4161 B4161 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO	 BO	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Alfamino Junior~~ ~~Alfamino Infant~~ ~~Nutramigen Enflora LGG~~ ~~Nutramigen LIPIL~~ ~~Pregestimil~~ ~~Gerber Extensive HA~~

Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age (Section 242.150)

National Procedure Code	M1	M2	M3	M4	Description	Covered Formulae
B4161 B4161 B4161 B4161 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 U8 U8	 BO 	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~Neocate Splash~~ ~~Peptamen Junior~~ ~~Vivonex Pediatric~~
B4162 B4162 B4162 B4162 Ages 0 – 4 Years requires PA	EP EP EP EP	 BO U7 U7	 BO	 	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~See list below~~
~~**Covered Formulae:**~~ ~~Calcilo XD~~ ~~Cyclinex 1~~ ~~Cyclinex 2~~ ~~Glutarex 1~~ ~~Glutarex 2~~ ~~Hominex 1~~ ~~Hominex 2~~ ~~I Valex 1~~ ~~I Valex 2~~ ~~Ketonex 1~~ ~~Ketonex 2~~					~~MSUD Maxamaid~~ ~~MSUD Maxamum~~ ~~MSUD Analog~~ ~~Periflex Infant~~ ~~Periflex Junior Plus~~ ~~Phenex 1~~ ~~Phenex 2~~	~~Propimex 1~~ ~~Propimex 2~~ ~~XLys, XTrp~~ ~~Maxamaid~~ ~~Xphe Maxamaid~~ ~~Xphe Maxamum~~ ~~Xphe, XTyr~~ ~~Maxamaid~~
B4162 B4162 B4162 B4162 Ages 0 – 4 Years requires PA	EP EP EP EP	U1 U1 U1 U1	 BO U7 U7	 BO	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes fats, carbohydrates, vitamins, and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	~~XMTVI Maxamaid~~

One (1) unit of service equals one-hundred (100) calories with a reimbursable maximum of thirty (30) units per day. Supplies furnished by prosthetics providers in conjunction with the nutritional formula must be billed to Medicaid with the prosthetics medical supply codes. These formulae are covered as nutritional supplements rather than as the sole source of nutrition.

NOTE: Beneficiaries who require enteral nutrition as the sole source of nutrition with the formulae being administered through a nasogastric, jejunostomy or gastrostomy tube should be referred to a hyperalimentation provider enrolled in the Medicaid Program.

Each claim should reflect a "from" and "through" date of service. The claims must not be filed until after the "through" date has elapsed. Claims may be submitted on either a weekly or a monthly basis.

~~NOTE: If a specific formula is not listed but is prescribed as the result of the EPSDT screening of an Arkansas Medicaid beneficiary, the provider may forward a copy of the screening and prescription, along with product information, to Utilization Review for consideration.~~

242.153 ~~MIC-KEY~~Low-Profile Skin Level Gastrostomy Tube (~~MIC-KEY~~Low-Profile Button) and ~~MIC-KEY~~Low-Profile Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages ~~11~~12-1-~~17~~20

NOTE: When billing for the ~~MIC-KEY~~Low-Profile Percutaneous Cecostomy Tube ~~and/~~or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. ~~If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.~~

National Procedure Code	M1	M2	PA	Description	Payment Method
B9998			Y	~~MIC-KEY~~Low-Profile Kit	Purchase
B9998	NU	U1	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 12" Length	Purchase
B9998	NU	U2	Y	SECUR-LOK Extension Set with 2 Port 'Y' and Clamp 24" Length	Purchase
B9998	NU	U3	Y	Bolus Extension Set with Single Port Clamp 12" Length	Purchase
B9998	NU	U4	Y	Bolus Extension Set with Single Port Clamp 24" Length	Purchase
B9998	NU	U5	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 12" Length	Purchase
B9998	NU	U6	Y	Bolus SECUR-LOK Extension Set Single Port w/Clamp 24" Length	Purchase
B9998	NU	U7	Y	Microvasive Adapter	Purchase
B9998	NU	U8	Y	Microvasive Decompression Tube	Purchase

TOC required

212.209 (DME) Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and Supplies for Beneficiaries of All Ages 12-1-20

The Arkansas Medicaid Program reimburses for the Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and supplies for Medicaid-eligible beneficiaries of all ages. Prior authorization (PA) from DHS or its designated vendor is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be completed and sent, along with sufficient medical documentation. View or print contact information for how to submit the request.

Field Code Changed

The Low-Profile Kit is benefit-limited to two (2) per state fiscal year (SFY). The accessories, extension sets, and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary.

212.210 DME Low-Profile Percutaneous Cecostomy Tube (Low-Profile Button) for Beneficiaries of All Ages 12-1-20

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes. (View ICD codes.)

Field Code Changed

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

44300	49442	49450

242.150 Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age 12-1-20

The following list provides the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

The coverage listed is payable only if the service is prescribed as a result of a Child Health Services (EPSDT) screening/referral.

No prior authorization is required for nutritional formulae for EPSDT beneficiaries from age five (5) years through twenty (20) years.

Prior authorization is required for beneficiaries from birth through four (4) years. Use of modifier **U7** in the following list will be necessary, as indicated.

To request prior authorization, providers should complete the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (DMS-679A), attaching a copy of the EPSDT screening/referral as well as a prescription signed by the beneficiary's PCP. View or print form DMS-679A. View or print contact information for how to submit the request.

Field Code Changed

Field Code Changed

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting

7. Home Health Services (Continued)

c. Medical Supplies, Equipment, and Appliances Suitable for Use in the Home (continued)

(12) ~~**MIC-KEY**~~**Low-Profile** Skin Level Gastrostomy Tube and Percutaneous Cecostomy Tube and Supplies

Effective for dates of service on or after September 1, 2000, reimbursement is based on the lesser of the provider's actual charge for the ~~MIC-KEY~~**Low-Profile** kits and accessories or the Title XIX (Medicaid) maximum. ~~The agency's rates were set as of September 1, 2000, and are effective for services on or after that date.~~This rate, along with all durable medical equipment rates (DME) ~~All rates~~ are published on the agency's website ~~(www.medicaid.state.ar.us)~~ . Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of DME services. ~~There is only one manufacturer of the MIC-KEY kits and accessories~~. The Title XIX (Medicaid) maximum for the kit and accessories is based on the manufacturer's list prices to the DME providers as of July 1, 2000 plus **ten percent (**10%**).** The State Agency will review the manufacturer's list prices annually and may adjust the Medicaid maximums if necessary. Arkansas Medicaid will reimburse providers for the kit and accessories as purchase only items.

Effective for dates of service on or after ~~March 1, 2014~~December 1, 2020, coverage of the ~~MIC-KEY~~**Low-Profile** for Percutaneous Cecostomy Tube will be reimbursed based on the above-mentioned methodology.

d. Physical Therapy

Refer to Item 4.b.(19).

8. Private Duty Nursing Services (Continued)

In addition, at least one (1) from each of the following conditions must be met:

1. Medications:
   - Receiving medication via gastrostomy tube (G-tube)
   - Have a Peripherally Inserted Central Catheter (PICC) line or central port

2. Feeding:
   - Nutrition via a permanent access such as G-tube, ~~Mickey~~Low-Profile Button, or Gastrojejunostomy tube (G-J tube). Feedings ~~feedings~~ are either bolus or continuous.
   - Parenteral nutrition (total parenteral nutrition)

Services are provided in the beneficiary's home, a Division of Developmental Disabilities (DDS) community provider facility, or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary. With substantiation, the maximum reimbursement may be extended.

MEDICALLY NEEDY

8. Private Duty Nursing to enhance the effectiveness of treatment for ventilator-dependent beneficiaries or non-ventilator dependent tracheotomy beneficiaries.

Enrolled providers are Private Duty Nursing Agencies licensed by **the** Arkansas ~~Department of Human Services, Division~~ **Department** of Health. Services are provided by Registered Nurses or Licensed Practical Nurses licensed by the Arkansas State Board of Nursing.

Services are covered for Medicaid-eligible beneficiaries age **twenty-one** (21) and over when determined medically necessary and prescribed by a physician.

Beneficiaries **twenty-one (**21**)** and over to receive PDN Nursing Services must require constant supervision, visual assessment, and monitoring of both equipment and patient. In addition, the beneficiary must be:

A. Ventilator dependent (invasive) or
B. Have a functioning trach requiring:
   1. ~~**requiring**~~ suctioning; ~~and~~
   2. oxygen supplementation; and
   3. receiving Nebulizer treatments or require Cough Assist / in-exsufflator devices.

In addition, at least one **(1)** from each of the following conditions must be met:

1. Medications:
   - Receiving medication via gastrostomy tube (G-tube)
   - Have a Peripherally Inserted Central Catheter (PICC) line or central port
2. Feeding:
   - Nutrition via a permanent access such as G-tube, ~~**Mickey**~~**Low-Profile** Button, **or** Gastrojejunostomy tube (G-J tube). **Feedings** ~~feedings~~ are either bolus or continuous.
   - Parenteral nutrition (total parenteral nutrition)

Services are provided in the beneficiary's home, a Division of Developmental Disabilities (DDS) community provider facility, or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of $80.00 per month, per beneficiary. With substantiation, the maximum reimbursement may be extended.