1. Inpatient Hospital Services (continued)

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Long-Acting Reversible Contraceptives (LARC)

Effective for claims with dates of service on or after January 1, 2024, all acute care hospitals will be reimbursed in addition to the per diem rates for Food and Drug Administration approved Long-Acting Reversible Contraceptives (LARCs) to include the IUD and contraceptive implants, and insertion and removal. LARC reimbursement will be the same as found in Attachment 4.19-B page 1v.

Select Carved-Out Drugs from Hospital Settings

Effective for claims with dates of service on or after January 1, 2026, all approved acute care hospitals will be reimbursed in addition to the per diem rates for selected carved-out drugs. Reimbursement will be the same as found in Attachment 4.19-B page 4aa. Approved acute care hospitals are those that have been certified and have appropriate agreements in place to provide the selected carve-out drugs.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye, or by an optometrist

a. Prescribed Drugs (Continued)

vii. Clotting Factor

a. Pharmacies dispensing Antihemophilic Factor products will be reimbursed at the lesser of methodology plus the established professional dispensing fee. The lesser of methodology for the allowed ingredient cost shall be the Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC).

b. Pharmacies dispensing Antihemophilic Factor products purchased through the Federal Public Health Service's 340B Drug Pricing Program (340B) by pharmacies that carve Medicaid into the 340B Drug Pricing Program shall be reimbursed the lesser of methodology for the allowed ingredient cost shall be the 340B actual invoice price, Wholesale Acquisition Cost (WAC) plus zero percent (+0%) or State Actual Acquisition Cost (SAAC). The 340B actual invoice price for each drug reimbursement covered under this program must be submitted to the Department prior to any claims being processed.

viii. Drugs Purchased at Nominal Price

Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed by their actual acquisition cost.

ix. Physician Administered Drugs

Reimbursement rates for Physician Administered Drugs are a "fee schedule" as determined by the Medicare fee schedule. If the Medicare rate is not available, then other published pricing Average Wholesale Price (AWP) less five percent (-5%) shall be used to determine reimbursement. Under the fee schedule methodology, reimbursement is based on the lesser of the billed charge for each procedure or the maximum allowable for each procedure.

x. Select Carved-Out Drugs from Hospital Settings

Effective for claims with dates of service on or after January 1, 2026, drugs that are reimbursed as a direct reimbursement will be reimbursed based on the provider's Actual Acquisition Cost for the drug, verified by the purchasing invoice.

b. State Upper Limit (SUL) shall apply to certain drugs identified administratively, judicially, or by a federal agency as having a published price exceeding the ingredient cost. The calculated SAAC shall be obtained from actual acquisition costs from multiple resources, if available. Depending on the variance, either the highest acquisition cost, an average of the acquisition costs, or invoice price shall be used in determining a SAAC. When Brand and Generic drugs are available for the same ingredient, reimbursement will be based on the Generic State Actual Acquisition Cost (SAAC).

TOC required

212.100 Scope – Inpatient

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"Inpatient hospital services" are defined in the Arkansas Medical Assistance Program as those items and services ordinarily furnished by the hospital for care and treatment of inpatients and are provided under the direction of a licensed practitioner (physician or dentist with staff affiliation) of a facility maintained primarily for treatment and care of injured persons, individuals with disabilities, or sick persons. Such inpatient services must be medically justified, documented, certified and re-certified by the Quality Improvement Organization (QIO) and are payable by Medicaid if provided on a Medicaid covered day.

A "Medicaid covered day" is defined as a day for which the beneficiary is Medicaid eligible, the patient's inpatient benefit has not been exhausted, the patient's inpatient stay is medically necessary, the day is not part of a hospital stay for a non-payable procedure or non-authorized procedure (see Sections 220.000 and 244.000), and the claim is filed on time. (See Section III of this manual for reference to "Timely Filing.")

The following services are covered inpatient hospital services if medically necessary for treatment of the patient and if the date of service is a Medicaid covered day:

A. **Accommodation**
"Accommodation" means the type of room provided for the patient while receiving inpatient hospital services. The Medicaid Program will cover the semi-private room or ward accommodations and intensive care. A private room will only be covered when such accommodations are medically necessary, as certified by the patient's attending physician. Private rooms are considered medically necessary only when the patient's condition requires him or her to be isolated to protect his or her health or welfare, or to protect the health of others.

B. **Operating Room**
Operating room charges for services and supplies associated with surgical procedures are covered inpatient hospital services.

C. **Anesthesia**
Anesthesia charges for services and/or supplies furnished by the hospital are covered inpatient hospital services.

D. **Blood Administration**
Blood, blood components and blood administration charges are covered when not available to the beneficiary from other sources. Hospitals are encouraged to replace blood that is used by a Medicaid beneficiary through his or her friends and relatives, or through the Red Cross whenever possible.

E. **Pharmacy**
Drugs and biologicals furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Take-home drugs are non-covered inpatient hospital services under the Arkansas Medicaid Program. Designated Cell and Gene Therapy Drugs furnished while a beneficiary is an inpatient in an acute care hospital will be treated as an outpatient hospital service and paid separately from the per diem. See Section 272.104 for prior authorization and special billing guidelines.

F. **Radiology and Laboratory**
The coverage of inpatient hospital services includes the non-physician services related to machine tests, laboratory and radiology procedures provided to inpatients. The hospital where the patient is hospitalized will be responsible for providing or securing these services. The party who furnishes these non-physician services is permitted to bill only the hospital.

If a patient is transferred to another hospital to receive services on an outpatient basis, the cost of the transfer is included in the hospital reimbursement amount. The ambulance company may not bill Medicaid or the beneficiary for the service.

G. **Medical, Surgical and Central Supplies**
Necessary medical and surgical supplies and equipment that are furnished by the hospital for the care and treatment of patients are covered inpatient hospital services. Supplies and equipment for use outside the hospital are not covered by Medicaid.

H. **Physical and Inhalation Therapy**
Physical and inhalation therapy and other necessary services, as well as supply charges for these services that are furnished by the hospital, are covered inpatient hospital services.

I. **Delivery Room**
Delivery room charges for services and supplies associated with obstetrical procedures are covered inpatient hospital services.

J. **Other**
Services other than the non-covered services identified in Section 212.200, which are not specified above.

272.103 Instructions for Prior Approval Letter Acquisition for Special Pharmacy, Therapeutic Agents and Treatments

1-15~~-15~~26

Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments. Approval letters may be obtained by the ordering physician and a copy provided to the hospital; however, the billing provider is ultimately responsible for meeting the documentation requirements for payment.

A. Before treatment begins, the Division of Medical Services (DMS)~~,~~ Medical Director for Clinical Affairs must approve any drug, therapeutic agent or treatment not listed as covered in this provider manual or in official DMS correspondence.

This requirement also applies to any drug, therapeutic agent or treatment with special instructions regarding coverage in the provider manual or in official DMS correspondence.

B. The Medical Director for Clinical Affairs' prior approval is required to ensure approval for medical necessity. Additionally, all other requirements must be met for reimbursement.

1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.
2. 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 claim. Any changes in treatment require resubmission and a new approval letter.

Send requests for a prior approval letter for pharmacy and therapeutic agents to the attention of the **Division of Medical Services, Medical Director of Clinical Affairs**.

272.104 ~~Reserved~~Cell and Gene Therapy Drugs When Hospitalization is Required for Administration

1-15~~-15~~26

Effective for claims with dates of service on or after January 1, 2026, all approved acute care hospitals will be reimbursed in addition to the per diem rates for designated cell and gene therapy drugs. Approved hospitals are those that are appropriately certified to provide the services and have contracts in place to administer the designated cell and gene therapy drugs. Hospitals requesting services for a member enrolled in a PASSE organization will be required to follow prior authorization and billing guidelines as below.

Prior Authorization:

A. **See a list of medications that require a prior authorization**.

B. Provider will submit prior authorization request to **Utilization Review**.

C. A Single Case Agreement will be completed for each request.

Billing Guidelines:

A. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).

B. If the hospital provides the cell and gene therapy, the hospital is to bill the cell and gene therapy drug on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. Use the identified **Cell and Gene Therapy Drug billing combinations** (Procedure Code, Modifier, and such) on the outpatient claim. Ensure the applicable NDC code is submitted on the claim.

C. Physician charges can be billed for the administration of the drug on a professional claim (CMS-1500), in addition to the physician's evaluation and management charges. When provided by the physician, the cell and gene therapy drug is billed by the physician on the professional claim instead of by the hospital. Use the **Cell and Gene Therapy Drug billing combinations** when submitting the billing codes on the professional claim. Ensure the applicable NDC code is submitted on the claim. A copy of the invoice with actual acquisition cost must be submitted with the claim.

D. The 340-B rules and modifiers to the Cell and Gene Therapy Drug billing code when they apply to the combinations.