ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TO: Arkansas Medicaid Health Care Providers – Ambulatory Surgical Center

EFFECTIVE DATE: November 1, 2017

SUBJECT: Provider Manual Update Transmittal ASC-1-17

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

Explanation of Updates

Section 216.400 has been updated with family planning procedure codes.

Section 216.910 has been removed.

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

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

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle

Dawn Stehle
Director

TOC required

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. AFMC forwards individual written confirmation to the surgeon.

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

E. When obtaining a Prior Authorization (PA) from the Arkansas Foundation for Medical Care (AFMC), please send your requests to the following:

In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for CHMS only	(479) 649-0776
Fax for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	https://afmc.org/reviewpoint/https://afmc.org/reviewpoint/
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 180001 Fort Smith, AR 72918-0001
Physical site location	5111 Rogers Avenue, Suite 476 Fort Smith, AR 72903
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays

222.000 Outpatient Surgeries That Require Prior Authorization 7-1-4417

A. The following procedure codes require prior authorization.

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

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

Outpatient Surgeryies Abortion Codes That Require Prior Authorization		
59840	59841	59866

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

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

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

223.000 Prior Authorization of ViscosupplementationReserved 7-1-1417

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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