REQUEST FOR GOVERNOR'S APPROVAL
2015 CPT & HCPCS Conversion

State Plan Amendment ☐ Waiver: New ☐ Renewal ☐ Amendment ☐

Federal Mandate: ☒ Yes ☐ No If yes, cite the regulation: 45 CFR Subpart J, Section 162.1002 & HIPAA

State Mandate: ☐ Yes ☒ No If yes, cite the regulation:

Priority Review Requested: ☒ Yes ☐ No

Proposed Effective Date: December 18, 2015

Summary: **To comply with federal regulation 45 CFR Subpart J, Section 162.1002; these Notices of Rulemaking informs providers of the implementation of the annual Current Procedure Codes, (CPT), and the annual Healthcare Common Procedure Codes Systems, (HCPCS). These data sets are created and published by the American Medical Association and the Centers for Medicare and Medicaid 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. This emergency notice will help expedite claims processing. Payable procedure codes will be added to the provider fee schedules and policy manuals will be updated as necessary. This will ensure that additional claims system testing will not be needed before implementation, resulting in subsequent delays and further lost efficiency of time. It will also help to put 2016 CPT/HCPCS planning, programming, testing, and promulgation processes back on its regular timelines.**

Emergency filing is necessary to allow providers to bill on the 2015 codes. Due to the implementation of ICD-10, work could not begin on implementing these codes until August 2015. The work will not be completed until December 2015.

Financial Impact:	Current Fiscal Year		Next Fiscal Year	
☐ None	SGR	$ 48,627	SGR	$ 92,175
☐ Unknown	FFP	$114,660	FFP	$212,738
	TOTAL	$163,287	TOTAL	$304,913

Public Hearing: ☐ Yes ☒ No

Controversial: ☐ Yes ☒ No

Emergency Rule: ☒ Yes ☐ No

Submitted to CMS: ☐ Yes ☒ No

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 Dawn Zekis

CONTACT PERSON Cathy Coffman

ADDRESS P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

PHONE NO. 501-537-1670 **FAX NO.** (501)682-2480 **E-MAIL** cathy.coffman@dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Tami Harlan

PRESENTER E-MAIL tami. harlan@dhs.arkansas.gov

INSTRUCTIONS

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

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

****

1. What is the short title of this rule? Notice of Rule Making Notice 002-15 and 003-15

2. What is the subject of the proposed rule? To inform providers of the 2015 Healthcare Common Procedural Coding System (HCPSC) and the 2015 Current Procedural Codes (CPT)

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ☒ No ☐

If yes, please provide the federal rule, regulation, and/or statute citation. 45 CFR Subpart A Section 162.1002 and the Health Insurance Portability and Accountability Act

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes ☒ No ☐

If yes, what is the effective date of the emergency rule? December 18, 2015

When does the emergency rule expire? February 13, 2016

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes ☒ No ☐

5. Is this a new rule? Yes ☒ No ☐
If yes, please provide a brief summary explaining the regulation. To comply with federal regulation 45 CFR Section 162.1002 implementing an annual code coversion.

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

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

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas 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 regulations 45 CFR Part 45 Section 162.1002. These notices of rulemaking are prepared in order to inform Arkansas Medicaid enrolled providers of the implementation of the annual CPT and HCPCS coding conversion and make non payable those deleted procedure codes from the 2014 code books. This rule is necessary for consistency with utilization of procudure 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 ☒
If yes, please complete the following:

Date: _____

Time: _____

Place: _____

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
January 28, 2016

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

March 1, 2016

12. Do you expect this rule to be controversial? Yes ☐ No ☒
    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 and interested providers are for this legislation.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE NO. (501)5372064 **FAX NO.** (501)682-2480 **EMAIL:** brian. jones @dhs.arkansas.gov

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

SHORT TITLE OF THIS RULE Notice of Rulemaking 002-15 & 003-15

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

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

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

   (a) How the additional benefits of the more costly rule justify its additional cost;

   _____

   (b) The reason for adoption of the more costly rule;

   _____

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

   _____

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

   _____

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	_____	General Revenue	_____
Federal Funds	_____	Federal Funds	_____
Cash Funds	_____	Cash Funds	_____
Special Revenue	_____	Special Revenue	_____
Other (Identify)	_____	Other (Identify)	_____

Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue	$48,627	General Revenue	$92,175
Federal Funds	$114,660	Federal Funds	$212,738
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$163,287	Total	$304,913

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

Current Fiscal Year	**Next Fiscal Year**
$	$

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year	**Next Fiscal Year**
$ $48,627	$ $92,175

This is required code conversion. Failure to implement these codes changes would result in Arkansas Medicaid being out of compliance with HIPAA requirements.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Summary for
2015 CPT and HCPCS Procedure Code Conversion

To comply with federal regulation 45 CFR Subpart J, Section 162.1002, these Notices of Rulemaking informs providers of the implementation of the annual Current Procedure Codes, (CPT), and the annual Healthcare Common Procedure Codes Systems, (HCPCS). These data sets are created and published by the American Medical Association and the Centers for Medicare and Medicaid 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. This emergency notice will help expedite claims processing. Payable procedure codes will be added to the provider fee schedules and policy manuals will be updated as necessary. This will ensure that additional claims system testing will not be needed before implementation, resulting in subsequent delays and further lost efficiency of time. It will also help to put 2016 CPT/HCPCS planning, programming, testing, and promulgation processes back on its regular timelines.

Emergency filing is necessary to allow providers to bill on the 2015 codes. Due to the implementation of ICD-10, work could not begin on implementing these codes until August 2015. The work will not be completed until December 2015.

NOTICE OF RULE MAKING

The Director of the Division of Medical Services hereby issues the following proposed medical assistance rule(s) under one or more of the following chapters or sections of the Arkansas Code: 20-10-211(a), 20-10-203(b), 20-76-433, 25-10-129, and Title 20, Chapter 77.

Effective for dates of service on or after December 18, 2015, the Division of Medical Services has implemented use of the 2015 national Healthcare Common Procedure Coding System (HCPCS) and Current Procedure Terminology (CPT) procedure codes. All procedure codes deleted from the 2014 HCPCS and CPT procedure books are non-payable effective for dates of service on and after December 18, 2015. This change will result in a total $ 304,913 budget increase over the next two state fiscal years.

The proposed policy is available for review at the Division of Medical Services, Program Planning and Development, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access it on the Medicaid website (www.medicaid.state.ar.us), and download it from the "Proposed Rules For Public Comment" section of the website's *General* menu. Policy accessed from this location will be watermarked with the word "Proposed". All comments must be submitted, to the above address, in writing no later than January 28, 2016.

If you need this material in a different format, such as large print, contact Program Development and Quality Assurance at 501-320-6429.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. **4501545928 EL**

Dawn Stehle /TAH

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

NOTICE OF RULE MAKING

TO: **Health Care Providers – Ambulatory Surgical Center, Area Health Education Centers (AHECs), Arkansas Department of Health, ARKids First-B, Child Health Services (EPSDT), Critical Access Hospital, Dental, End-Stage Renal Disease (ESRD), Federally Qualified Health Center (FQHC), Hospital, Independent Laboratory, Independent Radiology, Nurse Practitioner, Oral Surgeon, Pharmacy, Physician, Rural Health Clinic (RHC) and Vision Services**

DATE: **December 18, 2015**

SUBJECT: **2015 Current Procedure Terminology (CPT®) Code Conversion**

I. General Information

A review of the 2015 Current Procedural Terminology (CPT®) procedure codes has been completed, and the Arkansas Medicaid Program will begin accepting CPT® 2015 procedure codes for dates of service on and after December 18, 2015.

Procedure codes that are identified as deletions in CPT® 2015 (Appendix B) are **non-payable** for dates of service on and after December 18, 2015.

For the benefit of those programs impacted by the conversions, the Arkansas Medicaid Web site fee schedules will be updated soon after the implementation of the 2015 CPT® and Healthcare Common Procedural Coding System Level II (HCPCS) conversions.

II. Process for Obtaining Prior Authorization

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 for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx
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

The following 2015 CPT Lab Procedure Codes require prior authorization from AFMC:

81288	81313	81420	81431	81435
81436	81440	81445	81450	81455
81460	81465	81470	81471	81519

III. Non-Covered 2015 CPT® Procedure Codes

A. Effective for dates of service on and after December 18, 2015, the following CPT® procedure codes are non-covered:

33419	34839	77387	81246	81425	81426	81427
81430	89337	96127	99188	99490	99497	99498

B. All 2015 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 2015 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:

33987

IV. Hospital Providers

A. The following CPT® procedure code requires paper billing and documentation attached that describes the procedure and supports medical necessity:

45399

V. Independent Radiology

The following 2015 CPT® procedure codes are payable to Independent Radiology providers:

76641	76642	77061	77062
77063	77085	77086	77306
77307	77316	77317	77318
77385	77386		

VI. Nurse Practitioner

The payment for laboratory codes listed on the **Nurse Practitioner fee schedule** is based on Clinical Laboratory Improvement Amendments (C.L.I.A.) certification. Note that only C.L.I.A -certified providers may bill for lab procedures performed in the provider's office, place of service 11. Nurse practitioner providers that bill C.L.I.A -required laboratory procedure codes must have the current C.L.I.A certification on file with the Provider Enrollment Unit.

*The **technical** component of radiology procedure codes listed on the **Nurse Practitioner fee schedule** is payable when performed in the office place of service (11) if the nurse practitioner provider owns the equipment. The technical component must be billed on the claim with modifier **TC** added to the procedure code on the claim detail.

See Section X. for 2015 vaccine information.

VII. Oral Surgeons

The following 2015 procedure code is payable to Oral Surgeon providers:

20606

VIII. Physicians

The following CPT® procedure code requires paper billing and documentation attached that describes the procedure and supports medical necessity:

45399

IX. Vision

The following 2015 CPT® procedure code is payable to the Vision Program:

92145

X. Vaccine Information

A. CPT® procedure code 90630, "influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use."

Procedure Code	Required Modifiers	Age Restriction in Years	Special Instructions
90630	No	18y-49y	Covered for Arkansas Department of Health, Hospital, Nurse Practitioner, Pharmacy, and Physician providers. Coverage is limited to healthy individuals who are not pregnant.

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise 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 download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle/TAH

Dawn Stehle
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

NOTICE OF RULE MAKING

TO: **Health Care Providers – Ambulatory Surgical Center, Area Health Education Centers (AHECs), ARKids First-B, Critical Access Hospital, Dental, Home Health, End-Stage Renal Disease, Hospital, Independent Radiology, Nurse Practitioner, Physician, Podiatrist, Prosthetics, Rehabilitative Hospital and Transportation**

DATE: **December 18, 2015**

SUBJECT: **2015 Healthcare Common Procedural Coding System Level II (HCPCS) Code Conversion**

I. General Information

A review of the 2015 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 December 18, 2015. 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 2015 HCPCS Level II will become non-payable for dates of service on and after December 18, 2015.

Please NOTE: The Arkansas Medicaid website fee schedules will be updated soon after the implementation of the 2015 CPT and HCPCS conversions.

II. 2015 HCPCS Payable Procedure Codes Tables Information

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 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 CM diagnoses for which a procedure code may be used.

5. The fifth column contains information about the diagnosis list for which a procedure code may be used. (See Section V 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.

III. 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:

A. 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.

B. The Medical Director for Clinical Affairs' review is necessary 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 plan before beginning any 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 paper claim submission.

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

3. 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: Arkansas Medicaid Medical Director for Clinical Affairs 1020 West 4th Street, Suite 300 Little Rock, AR 72201	Fax: 501-212-8741 Phone: 501-212-8663

IV. Process for Obtaining Prior Authorization

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 for Molecular Pathology only	(479) 649-9413
Fax	(479) 649-0799
Web portal	http://review.afmc.org/MedicaidReview/iEXCHANGE%c2%ae.aspx
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

V. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), Diagnosis Range and Diagnosis Lists

Diagnosis is documented using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). Certain procedure codes are covered only for a specific primary diagnosis or a particular diagnosis range. **Diagnosis list 103** is specified here (**View ICD Codes.**). For any other diagnosis restrictions, reference the table for each individual program.

VI. Dental

The following 2015 ADA Dental procedure codes **are not covered** by Arkansas Medicaid.

D0171	D0351	D1353	D6110	D6111	D6112	D6113	D6114
D6115	D6116	D6117	D6549	D9219	D9931	D9986	D9987

VII. 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 Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0887	No	21y & up	Yes; see below	No	No	No	No

NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

J0888	No	21y & up	View ICD Codes.	No	No	No	No

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

VIII. HCPCS Procedure Codes Payable to Home Health Providers

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

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0887	No	21y & up	Yes; see below	No	No	No	No

NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

J0888	No	21y & up	View ICD Codes.	No	No	No	No

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

IX. HCPCS Procedure Codes Payable to Hospitals

The following information is related to procedure codes payable to Hospital providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9025	No	18y & up	No	103	No	No	No
C9026	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE: **Entyvio** is an integrin receptor antagonist for adult ulcerative colitis (UC). For adults with UC it must be moderately to severely active and have had an inadequate response with, or lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) inducing and maintaining clinical response; 2) inducing and maintaining clinical remission; 3) improving endoscopic appearance of the mucosa; or 4) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. For adults with Crohn's disease, it must be moderately to severely active with an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) achieving clinical response; 2) achieving clinical remission; or 3) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. Physician must submit a history and physical exam with the Prior Approval Letter to the Medical Director for Clinical Affairs.							
C9027	No	18y & up	Yes	103	Yes	No	Yes
NOTE: **Keytruda** is a human programmed death receptor-1 (PD-1)-blocking antibody indicated for the treatment of patients with unresectable or metastatic melanoma (View ICD Codes.) and disease progression following **ipilimumab** and, if BRAF V600 mutation positive, a BRAF inhibitor, in adult patients. The maximum dose is 2mg/kg. There will not be approvals for over this dose. If the patient is on high dose corticosteroids, **Keytruda** should be discontinued. If the patient has disease progression, **Keytruda** should be discontinued. Medical records documenting a history and physical exam showing use of **ipilimumab** first or a BRAF inhibitor should be forwarded to the Medical Director for Clinical Affairs. The patient should have a prognosis of 6 months. All treatments should be included in the medical records. Prior surgeries or other chemotherapeutics should be documented. A letter of Prior Approval will be approved for the length of treatment.							
C9136	No	No	View ICD Codes.	No	No	No	No
C9349	No	No	No	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9442	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE: **Beleodaq** is a histone decacetylase inhibitor indicated for the treatment of adult patients with relapsed or refractory peripheral T-cell lymphoma (PTCL). All previous treatments should be documented. A complete history and physical exam documenting previous treatments and results should be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter. Length of treatment should be specified.							
C9443	No	18y & up	No	No	No	No	No
C9444	No	18y & up	No	No	No	No	No
C9446	No	18y & up	No	No	No	No	No
C9739	No	No	No	No	No	No	No
NOTE: Covered for males only.							
C9740	No	No	No	No	No	No	No
NOTE: Covered for males only.							
G6015	No	No	No	No	No	No	No
J0153	No	No	No	No	No	No	No
J0887	No	21y & up	Yes; see below	No	No	No	No
NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**: • Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL. • If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera. • The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic. • Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.							

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0888	No	21y & up	View ICD Codes.	No	No	No	No

NOTE: For patients with CKD **not on dialysis**:
• Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  • The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  • Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
• If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.							

J1071	No	No	No	View ICD Codes.	No	No	No
J1439	No	18y & up	View ICD Codes.	No	No	No	No
J2274	No	No	No	No	No	No	No
J2704	No	3y & up	No	No	No	No	No
J3121	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J3145	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J7181	No	No	View ICD Codes.	No	No	No	No
J7201	No	No	No	No	No	No	No
J7327	No	18y & up	No	No	No	Yes	No
NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324, J7325 and J7327. 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 the Utilization Review prior authorization information in the provider manual. 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.							

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9267	No	No	No	103	No	No	No
J9301	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE: **Gazyva** is a CD-20 directed cytolytic antibody and is indicated, in combinations with chlorambucil, for the treatment of adult patients with previously untreated chronic lymphocytic leukemia. Patients should have a protocol with chlorambucil and a history and physical exam covering all treatments including failures to submit to the Medical Director for Clinical Affairs for a Prior Approval Letter. Dates of Service need to be included.							
Q4150	No	No	No	No	No	No	No
Q4152	No	No	No	No	No	No	No
Q4157	No	No	No	No	No	No	No
Q4160	No	No	No	No	No	No	No

X. HCPCS Procedure Codes Payable to Independent Radiology

The following information is related to procedure codes payable to Independent Radiology providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
G6015	No	No	No	No	No	No	No

XI. HCPCS Procedure Codes Payable to Nurse Practitioners

The following information is related to procedure codes payable to Nurse Practitioner providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
G6015	No	No	No	No	No	No	No
J0887	No	21y & up	Yes; see below	No	No	No	No

NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

J0888	No	21y & up	View ICD Codes.	No	No	No	No

NOTE: For patients with CKD **not on dialysis**:

- Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  - The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  - Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
- If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.

J3121	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J3145	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J9267	No	No	No	103	No	No	No

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

The following information is related to procedure codes payable to Physician and AHEC providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9025	No	18y & up	No	103	No	No	No
C9026	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: **Entyvio** is an integrin receptor antagonist for adult ulcerative colitis (UC). For adults with UC it must be moderately to severely active and have had an inadequate response with, or lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) inducing and maintaining clinical response; 2) inducing and maintaining clinical remission; 3) improving endoscopic appearance of the mucosa; or 4) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. For adults with Crohn's disease, it must be moderately to severely active with an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator, or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids: 1) achieving clinical response; 2) achieving clinical remission; or 3) achieving corticosteroid-free remission. Patient must have tried and failed **Enbrel**, **Humira** and **Cimzia**. Physician must submit a history and physical exam with the Prior Approval Letter to the Medical Director for Clinical Affairs.

C9027	No	18y & up	Yes	103	Yes	No	Yes

NOTE: **Keytruda** is a human programmed death receptor-1 (PD-1)-blocking antibody indicated for the treatment of patients with unresectable or metastatic melanoma (View ICD Codes.) and disease progression following **ipilimumab** and, if BRAF V600 mutation positive, a BRAF inhibitor, in adult patients. The maximum dose is 2mg/kg. There will not be approvals for over this dose. If the patient is on high dose corticosteroids, **Keytruda** should be discontinued. If the patient has disease progression, **Keytruda** should be discontinued. Medical records documenting a history and physical exam showing use of **ipilimumab** first or a BRAF inhibitor should be forwarded to the Medical Director for Clinical Affairs. The patient should have a prognosis of 6 months. All treatments should be included in the medical records. Prior surgeries or other chemotherapeutics should be documented. A letter of Prior Approval will be approved for the length of treatment.

C9136	No	No	View ICD Codes.	No	No	No	No
C9349	No	No	No	No	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9442	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE: **Beleodaq** is a histone decacetylase inhibitor indicated for the treatment of adult patients with relapsed or refractory peripheral T-cell lymphoma (PTCL). All previous treatments should be documented. A complete history and physical exam documenting previous treatments and results should be submitted to the Medical Director for Clinical Affairs for a Prior Approval letter. Length of treatment should be specified.							
C9443	No	18y & up	No	No	No	No	No
C9444	No	18y & up	No	No	No	No	No
C9446	No	18y & up	No	No	No	No	No
C9739	No	No	No	No	No	No	No
NOTE: Covered for males only.							
C9740	No	No	No	No	No	No	No
NOTE: Covered for males only.							
G6015	No	No	No	No	No	No	No
J0153	No	No	No	No	No	No	No
J0887	No	21y & up	Yes; see below	No	No	No	No

NOTE: The primary diagnosis should be (View ICD Codes.) with a secondary diagnosis of (View ICD Codes.). For patients with CKD **on dialysis**:

- Initiate Mircera treatment when the hemoglobin level is less than 10 g/dL.
- If the hemoglobin level approaches or exceeds 11 g/dL, reduce or interrupt the dose of Mircera.
- The recommended starting dose of Mircera for the treatment of anemia in adult CKD patients who are not currently treated with an ESA is 0.6 mcg/kg body weight administered as a single IV or SC injection once every two weeks. The IV route is recommended for patients receiving hemodialysis because the IV route may be less immunogenic.
- Once the hemoglobin has been stabilized, Mircera may be administered once monthly using a dose that is twice that of the every-two-week dose and subsequently titrated as necessary.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0888	No	21y & up	View ICD Codes.	No	No	No	No

NOTE: For patients with CKD **not on dialysis**:
• Consider initiating Mircera treatment only when the hemoglobin level is less than 10 g/dL and the following considerations apply:
  • The rate of hemoglobin decline indicates the likelihood of requiring an RBC transfusion, and
  • Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal.
• If the hemoglobin level exceeds 10 g/dL, reduce or interrupt the dose of Mircera and use the lowest dose of Mircera sufficient to reduce the need for RBC transfusions.							

J1071	No	No	No	103	No	No	No
J1439	No	18y & up	View ICD Codes.	No	No	No	No
J2274	No	No	No	No	No	No	No
J3121	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J3145	No	No	No	103	No	No	No
NOTE: Covered for males only.							
J7181	No	No	View ICD Codes.	No	No	No	No
J7201	No	No	No	No	No	No	No
J7327	No	18y & up	No	No	No	Yes	No
NOTE: Prior authorization is required for coverage of the **Hyaluronon** injection in the physician's office for procedure codes J7321, J7323, J7324, J7325 and J7327. 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 the Utilization Review prior authorization information in the provider manual. 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.							
J9267	No	No	No	103	No	No	No

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9301	No	18y & up	View ICD Codes.	No	Yes	No	Yes
NOTE: **Gazyva** is a CD-20 directed cytolytic antibody and is indicated, in combinations with chlorambucil, for the treatment of adult patients with previously untreated chronic lymphocytic leukemia Patients should have a protocol with chlorambucil and a history and physical exam covering all treatments including failures to submit to the Medical Director for Clinical Affairs for a Prior Approval Letter. Dates of Service need to be included.							
Q4150	No	No	No	No	No	No	No
Q4152	No	No	No	No	No	No	No
Q4157	No	No	No	No	No	No	No
Q4160	No	No	No	No	No	No	No

XIII. HCPCS Procedure Codes Payable to Podiatrists

The following information is related to procedure codes payable to Podiatrist providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
C9349	No	No	No	No	No	No	No
Q4150	No	No	No	No	No	No	No
Q4152	No	No	No	No	No	No	No
Q4157	No	No	No	No	No	No	No
Q4160	No	No	No	No	No	No	No

XIV. HCPCS Procedure Codes Payable to Prosthetics Providers

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 on requesting a DME prior authorization.

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
K0901	EP	0-20y	No	No	No	No	No
K0901	No	21y & up	No	No	No	Yes	No
K0902	EP	0-20y	No	No	No	No	No
K0902	No	21y & up	No	No	No	Yes	No
L3981	EP	0-20y	No	No	No	No	No
L3981	No	21y & up	No	No	No	No	No
L7259	EP	0-20y	No	No	No	No	No
L7259	No	21y & up	No	No	No	Yes	No

XV. HCPCS Procedure Codes Payable to Transportation Providers

The following information is related to procedure codes payable to Transportation providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0153	No	No	No	No	No	No	No

XVI. Miscellaneous Information

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

A. Existing HCPCS procedure codes **A6208**, **A6250**, **A6266** and **A6457** are payable to Prosthetics and Home Health providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
A6208	NU	No	No	No	No	No	No
A6250	NU	No	No	No	No	No	No
A6266	NU	No	No	No	No	No	No
A6457	NU	No	No	No	No	No	No

B. Effective July 1, 2015, for beneficiaries age 21 and over, a benefit limit of $60,000 per State Fiscal Year (July 1 through June 30) has been established for reimbursement for prosthetic devices. When the Medicaid maximum allowable for a prosthetic device item is $1,000 or more, prior authorization is required.

C. ICD code (View ICD Codes.) has been added to existing HCPCS procedure code **J0490**. All other criteria remain unchanged:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J0490	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: 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.

D. Existing HCPCS procedure code **J1446** is now payable to Hospital, Physician, and Nurse Practitioner providers:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J1446	No	21y & up	No	No	No	No	No

E. Existing HCPCS procedure code **J9228** will require ICD diagnosis as listed below in the Diagnosis table:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9228	No	18y & up	View ICD Codes.	No	Yes	No	Yes

NOTE: **Iplimumab** is indicated for treatment of unresectable or metastatic melanoma. It should be given every 3 weeks for a total of four doses. Liver function tests, thyroid function and clinical chemistries must be monitored before each dose. **Iplimumab** 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 **Iplimumab** 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 should be at least 18 years old and have a life expectancy of at least 4 months. It should not be used if patient had previous autoimmune disease requiring systemic therapy. A Prior Approval Letter with a history and physical exam must be sent to the Medical Director of Clinical Affairs.

F. Existing HCPCS procedure code J9047 no longer requires a Prior Approval letter. All other criteria remain unchanged:

Procedure Code	Modifier	Age Restriction	Diagnosis	Diagnosis List	Review	PA	Prior Approval Letter
J9047*	No	18y & up	View ICD Codes.	No	No	No	No

NOTE: **Kyprolis** is indicated for the treatment of adult patients with multiple myeloma, who have received at least two prior therapies including Velcade and an immunomodulary agent and have demonstrated disease progression on or within 60 days of completion of the last therapy. Approval is based upon response rate. A physical exam and history documenting the above requirements must be included. All monitoring and warnings and precautions from the Federal Drug Administration must be complied with for this drug to be approved. Females should avoid becoming pregnant. Consideration will be on a case-by-case basis.

XVII. Non-Covered 2015 HCPCS with Elements of CPT or Other Procedure Codes

The following new 2015 HCPCS procedure codes are not payable because these services are covered by a CPT code, another HCPCS code or a revenue code.

A9606	C2624	C2644	C9742

XVIII. Non-Covered 2015 HCPCS Procedure Codes

The following procedure codes are not covered by Arkansas Medicaid.

A4459	A4602	A7048	C9447	C9741	G0276	G0277	G0279
G0464	G0466	G0467	G0468	G0469	G0470	G0471	G0472
G0473	G6001	G6002	G6003	G6004	G6005	G6006	G6007
G6008	G6009	G6010	G6011	G6012	G6013	G6014	G6016
G6017	G6018	G0619	G0620	G0621	G6022	G6023	G6024
G6025	G6027	G6028	G6030	G6031	G6032	G6034	G6035
G6036	G6037	G6038	G6039	G6040	G6041	G6042	G6043
G6044	G6045	G6046	G6047	G6048	G6049	G6050	G6051
G6052	G6053	G6054	G6055	G6056	G6057	G6058	G9362
G9363	G9364	G9365	G9366	G9367	G9368	G9369	G9370
G9376	G9377	G9378	G9379	G9380	G9381	G9382	G9383
G9384	G9385	G9386	G9389	G9390	G9391	G9392	G9393
G9394	G9395	G9396	G9399	G9400	G9401	G9402	G9403
G9404	G9405	G9406	G9407	G9408	G9409	G9410	G9411
G9412	G9413	G9414	G9415	G9416	G9417	G9418	G9419
G9420	G9421	G9422	G9423	G9424	G9425	G9426	G9427
G9428	G9429	G9430	G9431	G9432	G9433	G9434	G9435
G9436	G9437	G9438	G9439	G9440	G9441	G9442	G9443
G9448	G9449	G9450	G9451	G9452	G9453	G9454	G9455
G9456	G9457	G9458	G9459	G9460	G9463	G9464	G9465
G9466	G9467	G9468	G9469	G9470	G9471	G9472	J0571
J0572	J0573	J0574	J0575	J1322	J7182	J7200	J7336
L6026	L8696	Q2052	Q4151	Q4153	Q4154	Q4155	Q4156
Q4158	Q4159	S1034	S1035	S1036	S1037	S8032	S9901

If you have questions regarding this notice, please contact the Hewlett Packard Enterprise 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 download from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Dawn Stehle/TAH

Dawn Stehle
Director