EXHIBIT I

DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

SUBJECT: Medicaid Limits on Lab/Radiology and SPA 2022-0003

DESCRIPTION:

Statement of Necessity

The 93rd General Assembly enacted Act 891, which modifies the annual cap on diagnostic laboratory services in the Medicaid program. The existing Medicaid cap is five hundred dollars ($500) for diagnostic laboratory procedures, including radiology services. Grouping radiology and diagnostic laboratory procedures within the same cap reduces the services a Medicaid beneficiary can receive.

Act 891 reduces the disparity in services by requiring a separate annual cap for each group and creating an exception for essential health benefit procedures. Diagnostic laboratory services now have an annual cap of five hundred dollars ($500), and radiology services have a separate annual cap of five hundred dollars ($500). Any laboratory or diagnostic procedure that is an essential health benefit will not count towards either annual cap.

Rule Summary

The Division of Medical Services (DMS) revises Section II of several provider manuals and the Medicaid State Plan to comply with Act 891. In general, the following changes were made:

- Replaced the term X-ray with radiology throughout each provider manual.
- Changed laboratory to diagnostic laboratory throughout each provider manual.
- Exempted laboratory or diagnostic procedures that are an essential health benefit as defined by the U.S. Preventive Services Task Force (USPSTF) from counting toward either of the two new annual caps. A hyperlink has been added to direct the provider to the listing of codes for the services.
- Made technical corrections to grammar and removed vendor names throughout each provider manual.
- Replaced procedure codes with a hyperlink throughout each provider manual.

The specific manual changes are as follows:

Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.

- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.
- Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

Ambulatory Surgical Center

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Certified Nurse-Midwife

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD)

Manual revised by adding the following language:
- Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). Designated laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD.
- Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits which are not exempt from Extension of Benefits request requirements. *See* Section 215. 041 for additional coverage information.
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- A separate claim must be filed for the tissue typing.
- Claims for the donor must be forwarded to the Transplant Coordinator.

Chiropractic

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Documentation requirements include emergency room records, diabetic and blood pressure flow sheets, obstetrical record, clinical indication for laboratory and radiology services, and ultrasound reports.

Federally Qualified Health Center

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Nurse Practitioner

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.

- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Clarification of benefit limits for Opioid Use Disorder and Obstetric ultrasounds.
- Clarification on extension of benefit requests.

Occupational, Physical, Speech-Language Therapy

Minor grammar corrections to manual.

Podiatrist

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated exemption list to include pregnancy and Opioid Use Disorder.

Portable X-Ray Services

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated requirements for extension of benefits and reconsideration requests.

Rehabilitative Hospital General Information

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.

- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Rural Health Clinic

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Visual Care

Manual revised by adding the following language:
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

State Plan Amendment (SPA)

Attachment 3.1-A, Page1f:
- Updated to indicate diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY, unless specifically exempt from one or both of the limits. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated language for extensions and exemptions of benefit limits.

Attachment 3.1-B, Page 2f:
- Updated to indicate diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY, unless specifically exempt from one or both of the limits. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated language for extensions and exemptions of benefit limits.

PUBLIC COMMENT: A public hearing was held on this rule on March 24, 2022. The public comment period expired April 9, 2022. The agency provided the following public comment summary:

Commenter's Name: Deirdre E. Flannery, on behalf of Quest Diagnostics

COMMENT: I appreciate the opportunity to offer comments on the proposed modification to the annual cap on diagnostics laboratory services in the Medicaid program to implement Act 891 of the 93rd General Assembly. As a long-standing Arkansas Medicaid Provider, Quest Diagnostics greatly supports a separate annual benefit for laboratory services to address the disparity in access to care for individuals when diagnostic laboratory services are grouped with radiology services as a combined Medicaid State Plan benefit. We applaud the Division of Medical Services (DMS) for its thoughtful benefit design, which recognizes exclusions to an annual cap for diagnostic insights that either: align with the United States Preventive Task Force guidelines; or are for the primary diagnosis of cancer, HIV, renal failure, opioid use disorder; or are for pregnancy to promote healthy maternal health outcomes. Further, we appreciate DMS' consideration for an extension of benefits for laboratory services in cases when an individual requires medically necessary diagnostic testing beyond the $500 annual cap. However, we are concerned that the documentation requirements for a lab testing extension of benefit is not practicable for an Independent Laboratory and the contemplated process will always result in a denial of the request purely on administrative grounds. We respectfully ask DMS to consider the indirect provider perspective as it seeks to finalize Section 229.120 Documentation Requirements for Independent Labs.

Quest Diagnostics is the world's leading provider of diagnostic information services and serves one in three adult Americans and half the physicians and hospitals in the United States annually. We proud serve as an Arkansas Medicaid Provider and are committed to powering affordable care that reduces health disparities. With our infrastructure in Arkansas of over 210 employees and 10 patient service centers, we service over 3,800 physicians and 43 hospitals, and handle 9,000 patient specimens daily. Quest's commitment to Arkansas has only strengthened in response to the COVID-19 pandemic. To date, we have conducted statewide over 400,000 viral PCR tests and nearly 54,000 serology tests to detect antibodies.

Section 229.120 Documentation Requirements – Quest Diagnostics urges DMS to accept the laboratory test requisition form as the sole documentation requirement for consideration of a laboratory extension of benefit request as independent clinical laboratories do not have access to the ordering physician's patient medical record. For example, the prevalence of electronic laboratory orders has significantly grown with the advancement and migration towards electronic medical records (EMR). However, the EMR often does not capture a physician signature. Consequently, it is increasingly difficult for an independent laboratory to produce a signed test order as contemplated in Section 229.120 (2)(B). It should be noted that federal guidelines under CMS no longer

require the signature for a clinical diagnostic laboratory test paid under the clinical laboratory fee schedule for Medicare purposes. This policy was retracted in the Vol. 76, No. 228 federal register published on Nov. 28, 2011. Further, clinical laboratories are increasingly unable to obtain signed medical records with an indication for diagnostic services from the ordering physician due to HIPAA minimum necessary concerns. The laboratory test requisition captures the clinical indication and can be used as the basis by which to evaluate for medical necessity. Accordingly, we ask that DMS remove documentation requirements related to signed test orders and medical records and evaluate medical necessity based on the test requisition.

Please include this letter and request as part of the formal rulemaking record. If it would be helpful, we will be happy to discuss this request in greater detail and can be reached at deirdre.e.flannery@questdiagnostics.com. Thank you for your consideration.

RESPONSE: We thank you for your comment. AR Medicaid has a current procedure in place for obtaining extension of benefits for Lab, Xray, or both. Physician Office and Outpatient Hospital Services. This Act increases the availability to allow five hundred dollars ($500) for lab and five hundred dollars ($500) for Xray. Your comments are important, and it may be possible to revisit for review with future manual updates.

The proposed effective date is July 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the cost to implement this rule is $5,973,405 for the current fiscal year ($1,695,252 in general revenue and $4,278,152 in federal funds) and $5,973,405 for the next fiscal year ($1,695,252 in general revenue and $4,278,152 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $1,695,252 for the current fiscal year and $1,695,252 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The purpose is to separate Lab and X-Ray maximum expenditure caps.

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

To be able to reimburse providers without additional administrative burden based on Act 891 of 2021.

(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;

Act 891 was legislatively mandated. Reimbursement is less than administrative 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;

None.

(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;

None at this time.

(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

N/A

(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.

The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 891 of 2021. The Act, sponsored by Senator Missy Irvin, modified the annual cap on diagnostic laboratory services in the Arkansas Medicaid Program.

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

DEPARTMENT/AGENCY Department of Human Services

DIVISION Division of Medical Services

DIVISION DIRECTOR Elizabeth Pitman

CONTACT PERSON Mac Golden

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

PHONE NO. 501-320-6383 **FAX NO.** 501-404-4619 **E-MAIL** Mac.E.Golden @dhs.arkansas.gov

NAME OF PRESENTER AT COMMITTEE MEETING Elizabeth Pitman

PRESENTER E-MAIL Elizabeth.Pitman@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:

Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
One Capitol Mall, 5th Floor
Little Rock, AR 72201

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1. What is the short title of this rule? Medicaid Limits on Lab/Radiology and SPA 2022-0003

2. What is the subject of the proposed rule? See Attached.

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. _____

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? _____

   When does the emergency rule expire? _____

   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. _____

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."**

See attached.

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Code §§ 20-76-201, 20-77-107, and 25-10-129

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

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://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/

9. Will a public hearing be held on this proposed rule? Yes ☒ No ☐
If yes, please complete the following:

Date: March 24, 2022
Time: 10:30 a.m.
Place: **https://us02web.zoom.us/j/81571147851**

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)
April 9, 2022

11. What is the proposed effective date of this proposed rule? (Must provide a date.)
July 1, 2022

12. Please provide a copy of the notice required under Ark. Code Ann. § 25-15-204(a), and proof of the publication of said notice. See Attached.

13. Please provide proof of filing the rule with the Secretary of State as required pursuant to Ark. Code Ann. § 25-15-204(e). See Attached.

14. 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. Unknown

NOTICE OF RULE MAKING

The Director of the Division of Medical Services of the Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129.

Effective July 1, 2022:

Act 891 of the 93rd General Assembly modified the annual cap on diagnostic laboratory services in the Medicaid program. To comply with the Act, the Division of Medical Services amends Section II of the following: Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual, Ambulatory Surgical Center, Certified Nurse-Midwife, Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD), Chiropractic, Federally Qualified Health Center, Nurse Practitioner, Occupational, Physical, Speech-Language Therapy, Podiatrist, Portable X-Ray Services, Rehabilitative Hospital General Information, Rural Health Clinic, and Visual Care provider manuals. DMS also amends the Medicaid State Plan.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 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 and download the proposed rule at https://humanservices.arkansas.gov/do-business-with-dhs/proposed-rules/. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than April 9, 2022. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on March 24, 2022, at 10:30a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at **https://us02web.zoom.us/j/81571147851**. The webinar ID is 815 7114 7851. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-396-6428.

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. 4502035775

Elizabeth Pitman, Director
Division of Medical Services

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Jason Callan

TELEPHONE 501-320-6540 **FAX** _____ **EMAIL:** Jason.Callan@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 Medicaid Limits on Lab/Radiology and SPA 2022-0003

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	$1,695,252	General Revenue	$1,695,252
Federal Funds	$4,278,152	Federal Funds	$4,278,152
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$5,973,405	Total	$5,973,405

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
$ _____

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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
$ 1,695,252

Next Fiscal Year
$ 1,695,252

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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; - ***The purpose is to separate Lab and X-Ray maximum expenditure caps.***

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute; - ***To be able to reimburse providers without additional administrative burden based on Act 891 of 2021.***

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and - ***Act 891 was legislatively mandated.***

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs; - ***Reimbursement is less than administrative 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; - ***None***

(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; - ***None at this time.***

(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 – ***N/A***

(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.

- ***The Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.***

Statement of Necessity and Rule Summary
Act 891 – Annual Cap on Radiology and Diagnostic Laboratory Services

Why is this change necessary? Please provide the circumstances that necessitate the change.
The 93rd General Assembly enacted Act 891 which modifies the annual cap on diagnostic laboratory services in the Medicaid program. The existing Medicaid cap is five hundred dollars ($500) for diagnostic laboratory procedures, including radiology services. Grouping radiology and diagnostic laboratory procedures within the same cap reduces the services a Medicaid beneficiary can receive.

Act 891 reduces the disparity in services by requiring a separate annual cap for each group and creating an exception for essential health benefit procedures. Diagnostic laboratory services now have an annual cap of five hundred dollars ($500), and radiology services have a separate annual cap of five hundred dollars ($500). Any laboratory or diagnostic procedure that is an essential health benefit will not count towards either annual cap.

What is the change? Please provide a summary of the change.

The Division of Medical Services (DMS) revises Section II of several provider manuals and the Medicaid State Plan to comply with Act 891. In general, the following changes were made:

- Replaced the term X-ray with radiology throughout each provider manual.
- Changed laboratory to diagnostic laboratory throughout each provider manual.
- Exempted laboratory or diagnostic procedures that are an essential health benefit as defined by the U.S. Preventive Services Task Force (USPSTF) from counting toward either of the two new annual caps. A hyperlink has been added to direct the provider to the listing of codes for the services.
- Made technical corrections to grammar and removed vendor names throughout each provider manual.
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The specific manual changes are as follows:

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Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
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- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Certified Nurse-Midwife

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Hospital/Critical Access Hospital (CAH)/End-Stage Renal Disease (ESRD)

Manual revised by adding the following language:

- Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)
- *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits which are not exempt from Extension of Benefits request requirements. See Section 215. 041 for additional coverage information.
- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- A separate claim must be filed for the tissue typing.
- Claims for the donor must be forwarded to the Transplant Coordinator.

Chiropractic

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Documentation requirements include emergency room records, diabetic and blood pressure flow sheets, obstetrical record, clinical indication for laboratory and radiology services, and ultrasound reports.

Federally Qualified Health Center

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Nurse Practitioner

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Clarification of benefit limits for Opioid Use Disorder and Obstetric ultrasounds.
- Clarification on extension of benefit requests.

Occupational, Physical, Speech-Language Therapy

Minor grammar corrections to manual.

Podiatrist

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated exemption list to include pregnancy and Opioid Use Disorder.

Portable X-Ray Services

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated requirements for extension of benefits and reconsideration requests.

Rehabilitative Hospital General Information

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Rural Health Clinic

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Visual Care

Manual revised by adding the following language:

- The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
- Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY/July 1 through June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY.
- Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

State Plan Amendment (SPA)

Attachment 3.1-A, Page1f:

- Updated to indicate diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY, unless specifically exempt from one or both of the limits. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated language for extensions and exemptions of benefit limits.

Attachment 3.1-B, Page 2f:

- Updated to indicate diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY, unless specifically exempt from one or both of the limits. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
- Updated language for extensions and exemptions of benefit limits.

Please attach additional documents if necessary

3. Other Diagnostic Laboratory ~~and or X-Ray~~Radiology/Other Services

Other medically necessary **diagnostic** laboratory ~~and or X-ray~~**radiology/other** services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory s~~S~~ervices **benefits** are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1 – June 30), **and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY**~~, unless specifically exempt from the limit.~~ **Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).**

Extensions of the benefit limit for recipients ~~age~~ twenty-one (21) **years of age** ~~old~~ or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per ~~State Fiscal Year~~SFY **diagnostic laboratory services** benefit limit**, and the five hundred dollars ($500) per SFY radiology/other services benefit limit.** ~~does~~ **do** not apply to services provided to recipients under ~~age~~ twenty-one (21) **years of age** ~~old~~ enrolled in the Child Health Services/**Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~ SFY **diagnostic** laboratory **services benefit limit**, and **the five hundred dollars ($500) per SFY** ~~X-ray~~**radiology/other** services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related **diagnostic** laboratory **services**, and ~~X-ray~~ **radiology/other** services will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limits** ~~and~~ **or the five hundred dollars ($500) per SFY** ~~X-ray~~ **radiology/other** services health benefit limits.

~~(1)~~(2) **Essential health benefit services as defined by the U.S. Preventive Services Task Force (USPSTF) are specifically exempt from the applicable limits.**

~~(2)~~(3) Drug screening will be specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~SFY **diagnostic** laboratory ~~and X-ray~~ services health benefit limits when the diagnosis is for **O**~~o~~pioid **U**~~u~~se **D**~~d~~isorder **(OUD),** and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment **(MAT)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) **diagnostic** laboratory ~~and X-ray~~ services health benefit limits.

~~(3~~4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~SFY **outpatient diagnostic** laboratory **services benefit limit** ~~and~~ **or the five hundred dollars ($500) per SFY** ~~X-ray~~**radiology/other** services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit,** ~~and~~ **or the recipient's five hundred dollars ($500) per SFY**~~X-ray~~ **radiology/other** services health benefit limits.

(4~~5~~) Portable X-Ray Services are subject to the five hundred dollars ($500) **per SFY radiology/other**

services benefit limit. Extensions of the benefit limit for recipients ~~age~~ twenty-one (21) **years of age** ~~old~~ or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in ~~his or her~~ **their** place of residence upon the written order of the recipient's physician. **Portable X-ray s**~~S~~ervices are limited to the following:

a. Skeletal films ~~which~~ **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films ~~which~~ **that** do not involve the use of contrast media; and
c. Abdominal films ~~which~~ **that** do not involve the use of contrast media.

(~~5~~6) Two (2) chiropractic X-rays are covered per ~~state fiscal year~~**SFY**. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients ~~age~~ twenty-one (21) **years of age** ~~old~~ or older will be provided through prior authorization, if medically necessary.

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED

Revised: ~~August 1, 2020~~July 1, 2022

MEDICALLY NEEDY

3. Other Diagnostic Laboratory ~~and~~ or Radiology/Other~~X-Ray~~ Services

Other medically necessary diagnostic laboratory ~~and~~ or radiology/other~~X-ray~~ services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory s~~S~~ervices benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY, July 1-June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY, ~~unless specifically exempt from the limit.~~ Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Extensions of the benefit limit for recipients ~~age~~ twenty-one (21) years of age ~~old~~ or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per ~~State Fiscal Year~~SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, ~~does~~ do not apply to services provided to recipients under ~~age~~ twenty-one (21) years of age ~~old~~ enrolled in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~SFY diagnostic laboratory services benefit limit, and the five hundred dollars ($500) per SFY radiology/other~~X-ray~~ services health benefit limits: (a) Malignant neoplasm; (b) HIV infection; and (c) renal failure. The cost of related diagnostic laboratory services and radiology/other~~X-ray~~ services will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limits ~~and~~ or the five hundred dollars ($500) per SFY radiology/other~~X-ray~~ services health benefit limits.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~SFY diagnostic laboratory ~~and X-ray~~ services health benefit limits when the diagnosis is for ~~O~~opioid ~~U~~use ~~D~~disorder (OUD), and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment (MAT) plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) diagnostic laboratory ~~and~~ or radiology/other~~X-ray~~ services health benefit limits.

~~(2)~~(3) Essential health benefit services as defined by the U.S. Preventive Services Task Force (USPSTF) are specifically exempt from the applicable limits.

~~(3)~~(4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per ~~State Fiscal Year~~SFY outpatient diagnostic laboratory services benefit limit ~~and~~ or five hundred dollars ($500) per SFY radiology/other~~X-ray~~ services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) per SFY diagnostic laboratory services benefit limit ~~and~~ or the recipient's five hundred dollars ($500) per SFY radiology/other~~X-ray~~ services health benefit limits.

~~(4)~~(5) Portable X-Ray Services are subject to the five hundred dollars ($500) per SFY X-ray services benefit limit. Extensions of the benefit limit for recipients ~~age~~ twenty-one (21) years of age ~~old~~ or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in ~~his or her place~~ their ~~of~~ residence upon the written order of the recipient's

physician. **Portable X-ray s**~~S~~ervices are limited to the following:

a. Skeletal films ~~which~~ **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films ~~which~~ **that** do not involve the use of contrast media; and
c. Abdominal films ~~which~~ **that** do not involve the use of contrast media.

~~(5)~~(6) Two (2) chiropractic X-rays are covered per ~~state fiscal year~~SFY. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients ~~age~~ twenty-one (21) **years of age** ~~old~~ or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

TOC required

215.110 Benefit Limits for Diagnostic Laboratory ~~, X-Ray and Machine Tests~~and Radiology/Other Services ~~7-1-14~~7-1-22

A. Both diagnostic ~~L~~laboratory and radiology/other ~~, X-ray and machine test~~services in all settings, including ASCs, are subject to a ~~$500.00 expenditure limit per state fiscal year (SFY, July 1 through June 30)~~benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Magnetic resonance imaging (MRI) services are exempt from the ~~laboratory and X-ray~~ radiology/other~~annual~~ services benefit limit per SFY.

~~B~~C. Individuals under ~~the age of~~twenty-one (21) years of age are not subject to the diagnostic laboratory services benefit limit ~~and~~or to the ~~X-ray~~radiology/other services benefit limit~~s~~, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

215.120 Benefit Extension Requests ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

~~A~~B. Requests to extend benefits for outpatient visits, ~~and~~ diagnostic laboratory services, and ~~x-ray~~ radiology/other services~~, including those for fetal ultrasounds and fetal non-stress tests,~~ must be submitted to DHS or its designated vendor.

View or print contact information for how to obtain information regarding submission processes.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

~~B~~C. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

~~C~~D. Additional information will be requested as needed to process a benefit extension request. Failures to ~~timely~~ provide requested additional information within the specified timeline will result in technical denials. Reconsiderations for technical denials are not available.

~~D~~E. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~E~~F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services, ~~f~~Form DMS-671 ~~12-15-14~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services~~,~~" ~~f~~Form DMS-671. **View or print form DMS-671.**

~~B~~C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped ~~and~~or electronic signatures are accepted.

~~C~~D. Dates of service must be listed in chronological order on ~~f~~Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of ~~four~~ procedures.

~~D~~E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

~~E~~F. Enter a valid procedure code or revenue code, modifier(s) when applicable and a brief narrative description of the procedure.

~~F~~G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

~~A~~C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, ~~and/~~or emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical records related to current pregnancy (when applicable); and
7. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services that are ordered with a copy of orders for diagnostic laboratory and ~~x-ray~~radiology/other services signed by the physician.

~~B~~D. Laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

212.000 Coverage of Chiropractic Services ~~11-1-06~~7-1-22

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. ~~-~~Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one~~age~~ (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program), except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

2. Medicaid cover~~sed~~ chiropractic services ~~are available to Medicaid~~for beneficiaries twenty-one~~aged~~ (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year ~~state fiscal year~~ (SFY: July 1 through June 30).

3. Two (2) chiropractic X-rays per ~~state fiscal year (July through June)~~SFY are covered by Medicaid. ~~-~~However, an X-ray is not required for treatment.

4. Chiropractic X-rays count against the ~~$500~~five-hundred-dollar per ~~state fiscal year~~SFY ~~laboratory and X-ray~~radiology/other services benefit limit.

~~-~~Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

5. The ~~laboratory and X-ray~~radiology/other services benefit may be extended when medically necessary (see Section 214.000). ~~-~~All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. ~~-~~Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. ~~-~~See **Section III** for instructions on filing joint Medicare/Medicaid claims.

214.110 Completion of ~~Request~~ Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory, and ~~X-Ray~~**Radiology/Other** Services" ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (~~P~~physician's ~~V~~visits), ~~O~~outpatient ~~S~~services (~~H~~hospital ~~O~~outpatient visits), ~~L~~laboratory ~~S~~services (diagnostic ~~L~~laboratory ~~T~~tests), and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc),~~ must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services: form (~~f~~Form DMS-671). **View or print form DMS-671.**

Complete instructions for accurate completion of ~~f~~Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements for Benefit Extension Requests ~~11-1-067-1-22~~

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limit~~sed service~~, all applicable records that support the medical necessity of extended benefits are required.

C~~B~~. Documentation requirements include the following:~~:~~

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order
   d. Include related diabetic and blood pressure flow sheets;
   ~~d~~e. Include a current medication list for the date of service;
   f. Include obstetrical record related to current pregnancy; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for laboratory and radiology/other services signed by the physician.
2. Diagnostic ~~L~~laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

242.100 Procedure Codes 7-1-~~07~~22

The procedure codes for billing chiropractic services are in the link below.

View or print the procedure codes for Chiropractic services.

~~98940~~	~~98941~~	~~98942~~	~~76499*~~

A. *Authorized ~~P~~procedure code~~s 76499 is to~~must be used when filing claims for chiropractic ~~x~~X-rays.

B. ~~This~~ Chiropractic X-rays are ~~benefit is~~ limited to two (2) per ~~s~~State ~~f~~Fiscal ~~y~~Year (SFY: July 1 through June 30). ~~-~~This service counts against the five-hundred-dollar ~~$500~~ per ~~beneficiary per state fiscal year~~SFY (per beneficiary) ~~laboratory and X-ray~~radiology/other services benefit limit.

C. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

TOC required

213.400 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services ~~10-13-037~~ 1-22

The Medicaid Program's diagnostic laboratory and ~~X-ray~~radiology/other services have benefit limits that apply to outpatient ~~laboratory~~ services~~, radiology services and machine tests (such as electrocardiograms)~~.

A. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~ July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

B. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

C. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

213.410 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology Other** Services Benefit Limits 7-1-~~2206~~22

A. Medicaid ~~has~~ established ~~a~~ maximum ~~paid~~ amounts (benefit limits~~ation~~) ~~of $500 per state fiscal year (July 1 through June 30)~~ for outpatient diagnostic laboratory and for outpatient radiology/other services for ~~beneficiaries~~ clients ~~aged~~ who are twenty-one (21) years of age ~~and~~ or older~~, for outpatient laboratory and machine tests and outpatient radiology~~.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~ July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. There ~~is~~are no diagnostic laboratory services benefit limits or ~~and X-ray~~radiology/other services benefit limits for ~~beneficiaries~~ clients under ~~age~~ twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

~~B~~C. There is no benefit limit on professional components of diagnostic laboratory or~~, X-ray radiology/other services and machine tests~~ for hospital inpatient~~s~~ treatment.

~~C~~D. There is no benefit limit on diagnostic laboratory services related to family planning. ~~(~~See Section 272.431 for the family-planning-related clinical laboratory procedures.~~)~~

~~D~~E. There is no benefit limit on diagnostic laboratory~~,~~ or ~~X-ray~~radiology/other ~~and machine test~~ services performed in conjunction with emergency services in an emergency department of a hospital.

213.420 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services Referral Requirements ~~10-1-15~~7-1-22

A. A ~~c~~Certified ~~n~~Nurse-~~m~~Midwife (CNM), referring a Medicaid ~~beneficiary~~ client for diagnostic laboratory services~~,~~ or radiology/other services ~~or machine testing services,~~ must specify a diagnosis code (ICD coding) for each test ordered and include ~~in the order,~~ pertinent supplemental diagnoses supporting the need for the test(s) in the order.

1. Reference diagnostic facilities, ~~and~~ hospital labs, and outpatient departments performing reference diagnostics rely on the referring physicians/ and CNMs~~certified nurse-midwives~~ to establish medical necessity.
2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities that are performing the tests.
3. ~~Certified nurse-midwive~~CNMs must follow Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
4. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
5. The following ICD diagnosis codes may not be used for billing. **(View ICD codes~~.~~).**

B. The following benefit limits apply:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY; and
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

214.100 Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory, and ~~X-Ray~~ **Radiology/Other** Services ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~A~~B. Certified Nurse Midwife (CNM) ~~R~~requests for extension of benefits for ~~certified nurse-midwife~~clinical, outpatient, diagnostic laboratory, and ~~x-ray~~radiology/other services must be ~~mailed to Arkansas Foundation for Medical Care, Inc. (AFMC), Attention EOB Review.~~ submitted to DHS or its designated vendor.

View or print ~~the Arkansas Foundation for Medical Care, Inc.~~ contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied ~~because~~ due to the patient's benefit limits being~~are~~ exhausted.

2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. ~~-~~Do not send a claim.

~~B~~C. A request for extension of benefits must be received ~~by AFMC~~ within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~1. Requests received after the 90-day deadline will not be considered.~~

~~2. AFMC will consider extending benefits in cases of medical necessity if all required documentation is received timely.~~

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations (of additionally requested information) are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.110 **Completion of ~~Request~~ Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services."** 7-1-~~07~~22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (~~P~~physician's ~~V~~visits), ~~O~~outpatient ~~S~~services (~~H~~hospital ~~O~~outpatient visits), diagnostic ~~L~~laboratory ~~S~~services (~~L~~laboratory ~~T~~tests) and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.),~~ must be submitted to ~~AFMC~~ DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and ~~X-Ray~~Radiology/Other Services" form (~~f~~Form DMS-671). ~~-~~**View or print form DMS-671.**

~~*~~2. Complete instructions for accurate completion of ~~f~~Form DMS-~~-~~671 (including indication of required attachments) accompany the form. ~~-~~All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 **Documentation Requirements** ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~A~~B. To request an extension of benefits for any ~~benefit-limited~~ service~~s~~, with benefit limits, all applicable records (that support the medical necessity of extended benefits) are required.

~~B~~C. Documentation requirements are as follows.

1. Clinical records *must*:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, ~~and/~~or emergency room records for relevant dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include ~~the~~ any obstetrical records related to a current pregnancy (when applicable); and
   g. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~x-ray~~radiology/other services signed by the physician.
2. Diagnostic ~~L~~laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

220.202 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services, ~~f~~Form DMS-671 ~~12-15-14~~7-1-22

A. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services," form (Form DMS-671).- **View or print ~~f~~Form DMS-671.**

B. The date of the request, and the signature of the provider's authorized representative, are required on the form. Stamped and electronic signatures are accepted.

C. Dates of service must be listed in chronological order on ~~f~~Form DMS-671. When requesting benefit extensions for more than four (4) encounters, use a separate form for each set of ~~four~~ encounters.

D. Enter a valid ICD-~~9~~ diagnosis code and brief narrative description of the diagnosis.

E. Enter the procedure code, modifier(s) (when applicable) and a brief narrative description of the procedure.

F. Enter the number of units (encounters) requested under the extension.

220.203 Documentation Requirements ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

~~A~~C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and/~~or~~ emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and

7. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~X-ray~~radiology/other services signed by the physician.

~~B~~D. Diagnostic ~~L~~laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

215.040 Benefit Limit in Outpatient Diagnostic Laboratory~~, Radiology~~ and ~~Machine Test~~Radiology/Other Procedures ~~10-1-15~~7-1-22

A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services~~,~~ and radiology/other services ~~and machine test procedures to a total of $500.00 per state fiscal year~~ per beneficiary ~~age~~ twenty-one (21) ~~and~~ years of age or older.

~~A~~1. The~~is yearly~~ benefit limit~~s~~ ~~is~~are based on the ~~S~~state ~~f~~Fiscal ~~y~~Year~~,~~ (SFY: July 1 through June 30).

2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. The~~is~~ benefit limit~~sation~~ appl~~yies~~ to claims payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, ~~c~~Certified ~~n~~Nurse ~~m~~Midwives (CNMs), ~~n~~Nurse ~~p~~Practitioners (NP), and ~~a~~Ambulatory ~~s~~Surgical ~~c~~Centers (ASCs).

C. Requests for extensions of ~~this~~ both benefits are considered for ~~-~~beneficiaries who require supportive treatment for maintaining life.

D. Extension of th~~is~~ese benefits ~~is~~are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (**View ICD Codes**~~.~~);
2. HIV infection and AIDS (**View ICD Codes**~~.~~);
3. Renal failure (**View ICD Codes**~~.~~);
4. Pregnancy* (**View ICD Codes**~~.~~); or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD (**View Laboratory and Screening Codes**).

E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)

~~E~~F. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar ~~$500.00 outpatient laboratory and X-ray annual~~radiology/other services benefit limit. ~~-~~Medical necessity for each MRI must be documented in the beneficiary's medical record. ~~-~~(Refer to Section 270.000 for billing information.)

~~F~~G. Cardiac catheterization procedures are exempt from the five-hundred~~-~~dollar~~$500.00~~ outpatient diagnostic laboratory services benefit limit and ~~X-ray~~the five-hundred-dollar radiology/other ~~annual~~ benefit limit. ~~-~~Medical necessity for each procedure must be documented in the beneficiaries' medical record.

~~G. Benefit Limits for Fetal Non-Stress Tests and Fetal Ultrasounds are addressed in Section 215. 041~~H. There are no benefit limits on outpatient diagnostic laboratory services~~,~~ or radiology/other servicesand machine test procedures for beneficiaries under ~~age~~ twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

215.100 Benefit Extension Requests

~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory ~~and~~ or X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

~~B~~C. Submit a copy of the Medical Assistance Remittance and Status Report ~~reflecting~~that reflects the claim's denial for exhausted benefits with the request. Do not send a claim.

~~C~~D. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~D~~E. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

~~E~~F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.101 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services, ~~f~~Form DMS-671

~~10-1-15~~7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services," form (Form DMS-671). **View or print ~~f~~Form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. ~~-~~Stamped ~~and~~ or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on ~~f~~Form DMS-671. ~~-~~When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of ~~four~~ procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid revenue code or ~~a CPT or HCPCS~~ procedure code (and modifiers when applicable)~~,~~ and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.440 CAH Benefit Limits

~~10-13-037~~-1-22

Inpatient stays, non-emergency outpatient visits, ~~and~~ diagnostic laboratory, and radiology/other ~~and diagnostic machine test coverage~~services in Critical Access Hospitals (CAHs) are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.

Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Benefit-limited services that are received in CAHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

217.141 Computed Tomographic Colonography (CT Colonography)

~~10-1-15~~7-1-22

A. The ~~following~~ procedure codes in the link below are covered for computed tomographic (CT) colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

~~74261~~	~~74262~~	~~74263~~

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical ~~-~~computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D

~~and/~~or 3D reconstruction. ~~-~~The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy)~~,~~ and air insufflation to achieve colonic distention.

2. Indications: ~~-~~Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. ~~-~~Failure to advance the colonoscopy may be secondary to a~~n obstruction~~ neoplasmic or~~,~~ spasmic obstruction, a redundant colon, diverticulitis extrinsic compression, or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized colon (proximal to the obstruction) would be of use to the surgeons in planning the operative approach to the patient.

3. Limitations:

   a. Virtual colonography is not reimbursable when used for screening or in the absence of any signs ~~of~~ indicating symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.

   b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening, or in the absence of signs or symptoms of disease.

   c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (~~e.g.,~~such as a biopsy) or for treatment (~~e.g.,~~such as a polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even ~~though~~ if performed for signs or symptoms of disease.

   d. CT colonography procedure codes are counted against the beneficiary's ~~annual lab and X- Ray~~ benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) for radiology/other services. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

   e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.

   f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient~~,~~ and indicate the reason(s) for which the service was performed. ~~-Claims submitted without ICD codes coded to the highest level of specificity will be denied.~~ ICD codes must be coded to the highest level of specificity or claims submitted with those ICD codes will be denied;

2. The results of an instrument/fiberoptic colonoscopy that was performed before the virtual colonoscopy (CT colonography~~-~~), ~~which~~if the virtual colonoscopy (CT colonography) was incomplete, must be retained in the patient's record~~.~~; and

3. The patient's medical record must include the following and be available upon request:

   a. The order or~~/~~ prescription from the referring physician;

   b. Description of polyps ~~/~~and lesion:

      i. Lesion size~~,~~ for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views, and t~~.~~ ~~T~~he type of view employed for measurement should be stated~~.~~;

      ii. Location (standardized colonic segmental divisions: rectum, sigmoid

colon, descending colon, transverse colon, ascending colon, and cecum);

iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa);

iv. Attenuation (soft-tissue attenuation or fat);

c. Global assessment of the colon (C-RADS categories of colorectal findings):

i. C0 – Inadequate study
poor prep (can't exclude > 10 lesions);

ii. C1 – Normal colon or benign lesions
no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum);

iii. C2 – Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings;

iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number;

v. C4 – Colonic mass, likely malignant;

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 – Inadequate Study limited by artifact;

ii. E1 – Normal exam or anatomic variant;

iii. E2 – Clinically unimportant findings (no work-up needed);

iv. E3 – Likely unimportant findings (may need work-up); for example, incompletely characterized lesions, ~~(e.g.)~~such as hypodense renal or liver lesion;

v. E4 – Clinically important findings (work-up needed), such as ~~(e.g.)~~ solid renal or liver mass, aortic aneurysm, adenopathy; and

e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy ~~which~~ that was incomplete due to obstruction.

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One~~Age~~ (21) Years of Age

~~8-1-21~~7-1-22

A. Requests for extended therapy services for beneficiaries under ~~age~~ twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under ~~age~~ twenty-one (21) years of age.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits being exceeded.

2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. ~~S~~With the request, submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial ~~with the request~~. Do not send a claim.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services," must be utilized ~~for requests for~~when requesting extended therapy services. **View or print ~~f~~Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable records that support the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization.

272.435 Tissue Typing ~~3-15-05~~7-1-22

A. ~~CPT~~ Authorized procedure codes ~~**86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821** and **86822**~~ are payable for the tissue typing for both the donor and the receiver.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. The tissue typing is subject to the ~~$500.00 annual lab and X-ray~~following benefit limits:~~.~~

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30);

~~1~~2. Extensions will be considered for beneficiaries who exceed the ~~$500.00~~five-hundred-dollar ~~annual lab and X-ray~~ benefit limit for diagnostic laboratory services; and~~.~~

~~2~~3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue-typing diagnostic laboratory procedures to determine a match for an unrelated bone marrow donor.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.510 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services Benefit Limits ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and ~~X-ray~~radiology/other services benefit limit~~s~~ each apply to the outpatient ~~laboratory services, radiology services and machine tests~~setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Medicaid ~~has~~ established a maximum ~~paid~~ amount (benefit limit~~ation~~) of five hundred dollar ($500) per ~~state fiscal year~~SFY for diagnostic laboratory services ~~(July 1 through June 30)~~ and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries ~~aged~~ twenty-one (21) years of age and older~~, for outpatient laboratory and machine tests and outpatient radiology~~. ~~-~~Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or ~~X-ray~~radiology/other services benefit limit for beneficiaries under ~~age~~ twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There ~~is~~ are no benefit limits on diagnostic laboratory services or radiology/other~~, X-ray, and machine test~~ services that are performed as emergency services~~,~~ and approved by DHS or its designated vendor for payment as emergency services.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

4. ~~The c~~Claims ~~processing system automatically overrides benefit limitations for services supported by the following diagnosis~~ with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (**View ICD Codes.**);
   b. HIV disease and AIDS (**View ICD Codes.**);
   c. Renal failure (**View ICD Codes.**);
   d. Pregnancy* (**View ICD Codes.**); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes.**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes.**)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have~~are~~ benefit limit~~sed~~ and are not exempt from Extension of Benefits request requirements. ~~-~~(See Section 214.630 for additional coverage information.)

~~B~~D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy, for maintaining life.

~~C~~E. Benefits may be extended for other conditions documented as medically necessary.

214.900 **Procedures for Obtaining Extension of Benefits** ~~2-1-05~~7-1-22

A. Nurse practitioners who perform diagnostic laboratory services or ~~and x-ray~~radiology/other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request an extension of benefits for diagnostic laboratory services ~~and x-ray~~or radiology/other services, use the following procedures.

214.910 **Extension of Benefits for Diagnostic Laboratory and ~~X-Ray~~Radiology/Other Services** ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

~~A~~B. Requests for extension of benefits for diagnostic laboratory services or~~and x-ray~~radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five--hundred-dollar~~$500~~ benefit limit~~s~~ for either diagnostic laboratory services or radiology/other services ~~are~~ is exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~B~~C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.920 Completion of ~~Request~~ Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services." ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (such as ~~P~~physician's visits or~~,~~ Nurse Practitioner visits), ~~O~~outpatient ~~S~~services (meaning, ~~H~~hospital ~~O~~outpatient visits), ~~L~~diagnostic laboratory ~~S~~services (meaning, ~~L~~laboratory ~~T~~tests) and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.),~~ must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services" form (~~f~~Form DMS-671). ~~-~~**View or print ~~f~~Form DMS-671.**

2. Complete instructions for accurate completion of ~~f~~Form DMS-671 (including indication of required attachments) accompany the form. ~~-~~All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG)

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limit~~sed service~~, all applicable records that support the medical necessity of extended benefits are required.

~~B~~C. Documentation requirements are as follows.

1. Clinical records *must:*

a. Be legible and include records supporting the specific request;
b. Be signed by the performing provider;
c. Include clinical, outpatient, and ~~/or~~ emergency room records for dates of service in chronological order;
d. Include related diabetic and blood pressure flow sheets;
e. Include a current medication list for the date of service;
f. Include the obstetrical record related to a current pregnancy when applicable; and
g. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~x-ray~~radiology/other services signed by the physician

2. Diagnostic ~~L~~laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

225.100 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services ~~9-1-20~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and ~~X-ray~~ radiology/other services benefit limit~~s~~, each applies~~y~~ to the outpatient ~~laboratory services,~~ setting.

1. ~~r~~Radiology/other services~~,~~ include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or ~~and~~ machine tests, ~~(~~such as electrocardiograms (ECG).
2. All benefit limits in this section are calculated per State Fiscal Year (SFY:~~,~~ July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Medicaid ~~has~~ established a maximum ~~paid~~ amount (benefit limit~~ation~~) of five hundred dollars ($500) per ~~state fiscal year (July 1 through June 30)~~SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services, for ~~beneficiaries~~clients~~aged~~ twenty-one (21) ~~and older~~years of age~~, for outpatient laboratory and machine tests and outpatient radiology~~.

1. There ~~is~~ are no laboratory or ~~and X-ray~~radiology/other benefit limits for ~~beneficiaries~~ clients under ~~age~~ twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. There is no benefit limit on professional components of laboratory~~,~~ ~~X-ray,~~ or radiology/other services ~~and machine tests~~ for hospital inpatient~~s~~ treatment.
3. There is no benefit limit on laboratory services related to family planning. ~~-~~See Section 292.552 for the family~~-~~planning-related clinical laboratory procedures exempt from the laboratory services benefit limit~~s~~.
4. There is no benefit limit on laboratory~~,~~ services or ~~X-ray, and machine test~~radiology/other services performed as emergency services.

~~B~~C. Extension-of-benefit requests are considered for medically necessary services.

1. ~~The c~~Claims ~~processing system automatically overrides benefit limitations for services supported by the following diagnoses~~with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (**View ICD Codes**~~.~~);
   b. HIV infection and AIDS (**View ICD Codes**~~.~~);
   c. Renal failure (**View ICD Codes**~~.~~);
   d. Pregnancy (**View ICD Codes**~~.~~); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (**View ICD OUD Codes**~~.~~). Designated laboratory tests will be ~~automatically overridden~~exempt from the laboratory services benefit limit when the diagnosis is ~~Opioid Use Disorder~~OUD. (**View Laboratory and Screening Codes**~~.~~).
2. Benefits may be extended for other conditions ~~for~~ based on documented reasons of medical necessity. ~~-~~Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

~~C~~D. Magnetic resonance imaging (MRI) ~~is~~ services are exempt from the five-hundred-dollar ($500) outpatient ~~laboratory and X-ray annual~~radiology/other benefit limit. Medical necessity for each MRI must be documented in the ~~beneficiary's~~ client's medical record.

~~D~~E. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) ~~annual~~ SFY benefit limit (each) for outpatient laboratory services and ~~X-ray~~for radiology/other services. Medical necessity for each procedure must be documented in the ~~beneficiary's~~ client's medical record.

229.100 Extension of Benefits for **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other**, Physician Office, and Outpatient Hospital Services ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

A~~B~~. Requests for extension of benefits for diagnostic laboratory, ~~and x-ray~~radiology/other, physician office, and outpatient services must be submitted to Department of Human Services (DHS) or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

~~B~~C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

229.110 Completion of ~~Request~~ Form DMS-671, "Request ~~F~~for Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory, and ~~X-Ray~~**Radiology/Other** Services" ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services, and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (~~P~~physician's ~~V~~visits), ~~O~~outpatient s~~S~~ervices (~~H~~hospital ~~O~~outpatient visits), diagnostic ~~L~~laboratory ~~S~~services (~~L~~laboratory ~~T~~tests), and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring – e.e.g.; e.k.g.; etc.),~~ must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services" form (~~f~~Form DMS-671). ~~-~~**View or print ~~f~~Form DMS-671**.
2. Instructions for accurate completion of ~~f~~Form DMS-671 (including indication of required attachments) accompany the form. ~~-~~All forms are listed and accessible in **Section V** of each Provider Manual.

229.120 **Documentation Requirements** ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: ~~/~~July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~A~~B. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

~~B~~C. Documentation requirements are as follows.

1. Clinical records *must*:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, ~~and/~~or emergency room records (as applicable) for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include the obstetrical record related to a current pregnancy (when applicable);

and

g. Include clinical indication for diagnostic laboratory and ~~x-ray~~ radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~x-ray~~radiology/other services signed by the physician.

2. Diagnostic ~~L~~laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

229.210 Process for Requesting Extended Therapy Services ~~8-1-21~~7-1-22

A. Requests for extended therapy services for ~~beneficiaries~~ clients under ~~age~~ twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support the request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.

2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671, ("Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services"), must be utilized ~~for requests for~~when a person is requesting extended therapy services. **View or print fForm DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the ~~beneficiary~~ client when a request is denied. Approved requests will be returned to the provider with information specific to the approval.

292.831 Billing for Tissue Typing ~~3-15-05~~7-1-22

A. ~~CPT~~ Authorized procedure codes ~~86805, 86806, 86807, 86808, 86812, 86813, 86816, 86817, 86821 and 86822~~ are payable for ~~the~~ tissue typing. ~~for~~ both for the donor and the receiver.

B. The tissue typing is subject to the following ~~$500 annual lab and X-ray~~ benefit limit.:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: /July 1 through June 30).

~~1~~2. Extensions will be considered for individuals who exceed the five-hundred-dollar ($500.00) ~~annual lab and X-ray~~ benefit limit for diagnostic laboratory services.

~~2~~3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue typing procedures to determine a match for an unrelated donor for a bone marrow transplant.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.300 **Diagnostic** Laboratory and ~~X-Ray~~**Radiology/Other** Services ~~10-13-037~~-**1-22**

A. ~~L~~Diagnostic laboratory services and ~~X-ray~~radiology/other services provided by a podiatrist will be included in the ~~$500 per state fiscal year~~ benefit limits for outpatient diagnostic laboratory services~~,~~ and outpatient radiology/other services ~~and machine tests for individuals age~~for individuals twenty-one (21) years of age and over.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. ~~-~~There ~~is~~are no benefits limit for individuals under ~~age~~twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. ~~-~~Benefit extensions may be granted in cases of documented medical necessity.

D. ~~-~~Section 242.130 contains procedure codes payable for diagnostic laboratory and ~~X-ray~~radiology/other services.

215.000 Extension of Benefits ~~10-1-157~~-**1-22**

Benefit extensions may be requested in the following situations:

A. Extension of Benefits for Medical Visits:

1. Extensions of benefits may be requested for medical visits that exceed the two (2) visits per ~~state fiscal year~~State Fiscal Year (SFY: July 1 through June 30) for individuals ~~age~~ twenty-one (21) years of age and over with documented medical necessity provided along with the request.

B. Extension of Benefits for Diagnostic Laboratory and ~~X-Ray~~Radiology/Other Services:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~3~~4. Extension of the benefits limit for diagnostic laboratory and ~~X-ray~~radiology/other services may be granted for individuals ~~age~~ twenty-one (21) years of age and over when documented to be medically necessary.

C. ~~NOTE:~~ ~~—~~The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

~~1.~~ Malignant Neoplasm **(View ICD codes)**;

2. HIV Infection, including AIDS **(View ICD codes)**; ~~and~~

3. ~~r~~Renal failure **(View ICD codes)**;~~.~~

4. Pregnancy (**View ICD Codes**); and

5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (**View ICD OUD Codes**) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (**View Laboratory and Screening Codes**).

TOC required

214.000 Benefit Limits ~~11-1-06~~7-1-22

A. Payments for portable X-ray services claims are applied to the ~~laboratory and X-ray~~radiology/other services benefit limit of five hundred dollars ($500.~~00~~) per ~~state fiscal year~~ State Fiscal Year (SFY: July 1 through June 30). ~~This yearly limit is based on the state fiscal year – July through June.~~

B. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~B~~C. Beneficiaries under ~~age~~ twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, ~~are~~ do not have benefit limits~~ed~~ for portable x-ray services.

214.100 Extension of Benefits for **Portable** X-Ray Services ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Requests for extension of benefits for ~~*~~Portable X-ray services must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for x-ray services.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. -Do not send a claim.

~~B~~C. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial. ~~1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.~~

~~2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. *Do not* send a claim.~~

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory, and ~~X-Ray~~**Radiology/Other** Services" ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (~~P~~physician's ~~V~~visits), ~~O~~outpatient ~~S~~services (~~H~~hospital ~~O~~outpatient visits), ~~L~~diagnostic laboratory ~~S~~services (~~L~~diagnostic laboratory ~~T~~tests) and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring - e.e.g.; e.k.g.; etc.),~~ must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for how to obtain information regarding submission processes. ~~AFMC for consideration.~~

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and ~~X-Ray~~Radiology Other Services" form (~~f~~Form DMS-671). ~~-~~**View or print ~~f~~Form DMS-671.**

2. Instructions for accurate completion of ~~f~~Form DMS- 671 (including indication of required attachments) accompany the form. -All forms are listed and accessible in **Section V** of each Provider Manual.

214.120 Documentation Requirements for Extension of Benefits Request ~~11-1-06~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~A~~B. To request extension of benefits for any ~~benefit limited~~ services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:

   a. Be legible and include records supporting the specific request;

   b. Be signed by the performing provider;

   c. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);

   d. Include related diabetic and blood pressure flow sheets;

   e. Include current medication list for the dates of service;

   f. Include obstetrical record related to current pregnancy; and

   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

~~B~~2. Radiology/other reports *must* include:

   ~~1~~a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;

   ~~2~~b. Signed orders for diagnostic laboratory and radiology/other services;

   ~~3~~c. Results signed by the performing provider; and

   ~~4~~d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

215.120 Benefit Extension Requests ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Requests to extend benefits for outpatient rehabilitative hospital visits, ~~and~~ diagnostic laboratory services, and ~~X-ray~~radiology/other services~~, including those for fetal non-stress tests and fetal ultrasounds,~~ must be mailed to DHS or its designated vendor.

~~–~~**View or print contact information for how to submit the request.**

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

~~B~~C. A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits must accompany the request for review. -Do not send a claim.

~~C~~D. Additional information needed to process a benefit extension may be requested from the provider. -Failures to provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

~~D~~E. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

~~E~~F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services, ~~f~~Form DMS-671 ~~12-15-14~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Consideration of requests for benefit extensions requires correct completion of all fields of ~~f~~Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services." -**View or print ~~f~~Form DMS-671.**

~~B~~C. The request date and the signature of the provider's authorized representative are required on the form. ~~-S~~Both stamped and electronic signatures are accepted.

~~C~~D. Dates of service must be listed in chronological order on ~~f~~Form DMS-671. -When requesting benefit extension for more than four (4) encounters, use a separate form for each set of ~~four~~ encounters.

~~D~~E. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

~~E~~F. Enter a valid revenue code or ~~a CPT or HCPCS~~ procedure code (and modifiers, when applicable) and a brief narrative description of the procedure.

~~F~~G. Enter the number of units of service requested under the extension.

215.122 **Documentation Requirements** ~~2-1-057~~-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

~~A~~C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and~~/or~~ emergency room records for the dates of service (in chronological order);
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include the obstetrical record related to current pregnancy (if~~when~~ applicable); and
7. Include clinical indication for diagnostic laboratory and ~~X-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~X-ray~~radiology/other services signed by the physician

~~B~~D. Diagnostic ~~L~~laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and ~~X-ray~~radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests ~~when~~ if applicable.

216.112 **Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One ~~Age~~ (21) Years of Age** ~~8-1-21~~7-1-22

A. Requests for extended therapy services for beneficiaries under ~~age~~ twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information for how to submit the request.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print ~~f~~Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number.

TOC required

218.311 **Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services, ~~f~~Form DMS-671** ~~12-15-14~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

~~A~~B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services~~,~~" form. (Form DMS-671). ~~-~~**View or print ~~f~~Form DMS-671.**

~~B~~C. The date of the request and the signature of the provider's authorized representative are required on the form. ~~-~~Stamped and electronic signatures are accepted.

~~C~~D. Dates of service must be listed in chronological order on ~~f~~Form DMS-671. ~~-~~When requesting benefit extension for more than four (4) encounters, use a separate form for each set of ~~four~~ encounters.

~~D~~E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

~~E~~F. Enter the revenue code, modifier(s) when applicable and the applicable nomenclature.

~~F~~G. Enter the number of units (encounters) requested under the extension.

218.312 **Documentation Requirements** ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

~~A~~C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and~~/or~~ emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and
7. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~X-ray~~radiology/other services signed by the physician.

~~B~~D. Diagnostic ~~L~~laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles, and fetal non-stress tests (if~~when~~ applicable)

TOC not required

216.300 Process for Requesting Extended Therapy Services 7-1-~~18~~22

A. Requests for extended therapy services for beneficiaries under ~~age~~twenty-one (21) years of age and adults receiving services in an Adult Developmental Day Treatment (ADDT) must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO). **View or print the QIO contact information.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received by the QIO within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.
4. The QIO will not accept requests sent via electronic facsimile (FAX) or e-mail.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print ~~f~~Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, including credentials, and date the request form. An electronic signature is accepted, provided it ~~is in compliance~~complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

TOC required

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, **Diagnostic** Laboratory, and ~~X-Ray~~**Radiology/Other** Services" ~~8-1-21~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for ~~C~~clinical ~~S~~services (~~P~~physician's ~~V~~visits) ~~O~~outpatient ~~S~~services (~~H~~hospital ~~O~~outpatient visits), diagnostic ~~L~~laboratory ~~S~~services (~~L~~laboratory ~~T~~tests), and ~~X-ray~~radiology/other services ~~(X-ray, Ultrasound, Electronic Monitoring-EEG, EKG, etc.)~~ must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain instructions for submitting the request.

1. Requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and ~~X-Ray~~Radiology/Other Services" form (~~f~~Form DMS-671). **View or print Form DMS-671 ~~form~~.**

2. **Instructions for accurate competition of ~~f~~Form DMS-671 (including indication of required attachments) accompany the ~~f~~Form. All forms are listed and accessible in Section V of each provider manual.**

216.220 Documentation Requirements ~~2-1-05~~7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

~~A~~B. To request extension of benefits for any ~~benefit limited~~ services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

~~B~~C. Documentation requirements are as follows.

1. Clinical records must:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and~~/or~~ emergency room records for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include current medication list for date of service;
   f. Include the obstetrical record related to the current pregnancy; and
   g. Include clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered with a copy of orders for diagnostic laboratory and ~~x-ray~~radiology/other services signed by the physician.
2. Diagnostic ~~L~~laboratory and radiology/other reports must include:
   a. Clinical indication for diagnostic laboratory and ~~x-ray~~radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

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3. Other **Diagnostic** Laboratory **or Radiology/Other** Services

Other medically necessary **diagnostic** laboratory **or radiology/other** services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice, as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services **benefits** are limited to five hundred dollars ($500) per State Fiscal Year (**SFY,** July 1 – June 30), **and radiology/other services benefits are separately limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).**

Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per **SFY diagnostic laboratory services** benefit limit**, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do** not apply to services provided to recipients under twenty-one (21) **years of age** enrolled in the Child Health Services/**Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory **services benefit limit,** and **the five hundred dollars ($500) per SFY radiology/other** services health benefit limit**s: (a)** Malignant neoplasm; **(b)** HIV infection; and **(c)** renal failure. The cost of related **diagnostic** laboratory **services,** and **radiology/other** services will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limits or the five hundred dollars ($500) per SFY radiology/other** services health benefit limits.

(2) Essential health benefit services as defined by the U.S. Preventive Services Task Force (USPSTF) are specifically exempt from the applicable limits.

(3) Drug screening will be specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory services health benefit limit when the diagnosis is for **O**pioid **U**se **D**isorder **(OUD),** and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment **(MAT)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) **diagnostic** laboratory services health benefit limit.

(4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **SFY outpatient diagnostic** laboratory **services benefit limit or the five hundred dollars ($500) per SFY radiology/other** services health benefit limits. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit, or the recipient's five hundred dollars ($500) per SFY radiology/other** services health benefit limits.

(5) Portable X-Ray Services are subject to the five hundred dollars ($500) **per SFY radiology/other services** benefit limit. Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in **their** place of residence upon the written order of the recipient's physician. **Portable X-ray s**ervices are limited to the following:

a. Skeletal films **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films **that** do not involve the use of contrast media; and
c. Abdominal films **that** do not involve the use of contrast media.

(6) Two (2) chiropractic X-rays are covered per **SFY**. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary.

3. Other **Diagnostic** Laboratory **or Radiology/Other** Services

Other medically necessary **diagnostic** laboratory **or radiology/other** services are covered when ordered and provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law in the practitioner's office or outpatient hospital setting or by a certified independent laboratory which meets the requirements for participation in Title XVIII.

Diagnostic laboratory services **benefits** are limited to five hundred dollars ($500) per State Fiscal Year (**SFY,** July 1-June 30), **and radiology/other services benefits are limited to five hundred dollars ($500) per SFY. Radiology/other services include, but are not limited to, diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).**

Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. The five hundred dollars ($500) per **SFY diagnostic laboratory services** benefit limit**, and the five hundred dollars ($500) per SFY radiology/other services benefit limit, do** not apply to services provided to recipients under twenty-one (21) **years of age** enrolled in the Child Health Services**/Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) Program.

(1) The following diagnoses are specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory **services benefit limit,** and **the five hundred dollars ($500) per SFY radiology/other** services health benefit limits**: (a)** Malignant neoplasm; **(b)** HIV infection; and **(c)** renal failure. The cost of related **diagnostic** laboratory **services** and **radiology/other** services will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit or the five hundred dollars ($500) per SFY radiology/other** services health benefit limit.

(2) Drug screening will be specifically exempt from the five hundred dollars ($500) per **SFY diagnostic** laboratory services health benefit limit when the diagnosis is for **O**pioid **U**se **D**isorder **(OUD),** and the screening is ordered by an X-DEA-waivered provider as part of a Medication Assisted Treatment **(MAT)** plan. The cost of these screenings will not be included in the calculation of the recipient's five hundred dollars ($500) **diagnostic** laboratory **or radiology/other** services health benefit limits.

(3) Essential health benefit services as defined by the U.S. Preventive Services Task Force (USPSTF) are specifically exempt from the applicable limits.

(4) Magnetic Resonance Imaging (MRI) and Cardiac Catheterization procedures are specifically exempt from the five hundred dollars ($500) per **SFY** outpatient **diagnostic** laboratory **services benefit limit or five hundred dollars ($500) per SFY radiology/other** services health benefit limit. The cost of these procedures will not be included in the calculation of the recipient's five hundred dollars ($500) **per SFY diagnostic** laboratory **services benefit limit** or **the recipient's five hundred dollars ($500) per SFY radiology/other** services health benefit limit.

(5) Portable X-Ray Services are subject to the five hundred dollars ($500) **per SFY X-ray services** benefit limit. Extensions of the benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary. Services may be provided to an eligible recipient in **their** residence upon the written order of the recipient's physician. **Portable X-ray** services are limited to the following:

a. Skeletal films **that** involve arms and legs, pelvis, vertebral column, and skull;
b. Chest films **that** do not involve the use of contrast media; and
c. Abdominal films **that** do not involve the use of contrast media.

(6) Two (2) chiropractic X-rays are covered per **SFY**. Chiropractic X-Ray Services are subject to the five hundred dollars ($500) benefit limit **per SFY for radiology/other services**. Extensions of the **radiology/other services** benefit limit for recipients twenty-one (21) **years of age** or older will be provided through prior authorization, if medically necessary.

4.a. Nursing Facility Services - Not Provided

TOC required

215.110 Benefit Limits for Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. Both diagnostic laboratory and radiology/other services in all settings, including ASCs, are subject to a benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Magnetic resonance imaging (MRI) services are exempt from the radiology/other services benefit limit per SFY.

C. Individuals under twenty-one (21) years of age are not subject to the diagnostic laboratory services benefit limit or to the radiology/other services benefit limit, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

215.120 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Requests to extend benefits for outpatient visits, diagnostic laboratory services, and radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information for how to obtain information regarding submission processes.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

D. Additional information will be requested as needed to process a benefit extension request. Failures to provide requested additional information within the specified timeline will result in technical denials. Reconsiderations for technical denials are not available.

E. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" Form DMS-671. **View or print form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid procedure code or revenue code, modifier(s) when applicable and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;

2. Be signed by the performing provider;
3. Include clinical, outpatient, or emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical records related to current pregnancy (when applicable); and
7. Include clinical indication for diagnostic laboratory and radiology/other services that are ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

212.000 Coverage of Chiropractic Services 7-1-22

A. Chiropractic services must be administered by a licensed chiropractor, meeting minimum standards promulgated by the Secretary of Health and Human Services under Title XVIII of the Social Security Act. Manipulation of the spine for the treatment of subluxation is the **only** chiropractic service covered by Medicaid.

B. Benefits.

1. Benefits are not limited for beneficiaries under twenty-one (21) years of age (in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program), except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. Medicaid covers chiropractic services for beneficiaries twenty-one (21) years of age and older, with a benefit limit of twelve (12) visits per State Fiscal Year (SFY: July 1 through June 30).
3. Two (2) chiropractic X-rays per SFY are covered by Medicaid. However, an X-ray is not required for treatment.
4. Chiropractic X-rays count against the five-hundred-dollar per SFY radiology/other services benefit limit.

   Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
5. The radiology/other services benefit may be extended when medically necessary (see Section 214.000). All X-rays and documentation must be kept in the beneficiary's medical record for a period of five (5) years for audit purposes. Chiropractic services may be provided in the provider's office, the patient's home, a nursing home, or another appropriate place.

C. For beneficiaries who are eligible for Medicare and Medicaid, see Section I of this manual for additional coinsurance and deductible information. See Section III for instructions on filing joint Medicare/Medicaid claims.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), laboratory services (diagnostic laboratory tests), and

radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services: form (Form DMS-671). View or print form DMS-671.

Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

214.120 Documentation Requirements for Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements include the following:

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include obstetrical record related to current pregnancy; and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

242.100 Procedure Codes 7-1-22

The procedure codes for billing chiropractic services are in the link below.

View or print the procedure codes for Chiropractic services.

A. *Authorized procedure codes must be used when filing claims for chiropractic X-rays.

B. Chiropractic X-rays are limited to two (2) per State Fiscal Year (SFY: July 1 through June 30). This service counts against the five-hundred-dollar per SFY (per beneficiary) radiology/other services benefit limit.

C. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

TOC required

213.400 Diagnostic Laboratory and Radiology/Other Services 7-1-22

The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

A. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

B. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

C. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

213.410 Diagnostic Laboratory and Radiology Other Services Benefit Limits 7-1-22

A. Medicaid established maximum amounts (benefit limits) for outpatient diagnostic laboratory and for outpatient radiology/other services for clients who are twenty-one (21) years of age or older.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. There are no diagnostic laboratory services benefit limits or radiology/other services benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. There is no benefit limit on professional components of diagnostic laboratory or radiology/other services for hospital inpatient treatment.

D. There is no benefit limit on diagnostic laboratory services related to family planning. (See Section 272.431 for the family-planning-related clinical laboratory procedures.)

E. There is no benefit limit on diagnostic laboratory or radiology/other services performed in conjunction with emergency services in an emergency department of a hospital.

213.420 Diagnostic Laboratory and Radiology/Other Services Referral Requirements 7-1-22

A. A Certified Nurse-Midwife (CNM), referring a Medicaid client for diagnostic laboratory services or radiology/other services must specify a diagnosis code (ICD coding) for each test ordered and include pertinent supplemental diagnoses supporting the need for the test(s) in the order.

1. Reference diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring physicians and CNMs to establish medical necessity.
2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities that are performing the tests.
3. CNMs must follow Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
4. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
5. The following ICD diagnosis codes may not be used for billing. **(View ICD codes).**

B. The following benefit limits apply:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY; and
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

214.100 Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Certified Nurse Midwife (CNM) requests for extension of benefits for clinical, outpatient, diagnostic laboratory, and radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied due to the patient's benefit limits being exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations (of additionally requested information) are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory and radiology/other services have benefit limits that apply to outpatient services.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services" form (Form DMS-671). View or print form DMS-671.
2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

214.120 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request an extension of benefits for any services with benefit limits, all applicable records (that support the medical necessity of extended benefits) are required.

C. Documentation requirements are as follows.

1. Clinical records *must*:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, or emergency room records for relevant dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include any obstetrical records related to a current pregnancy (when applicable); and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by the performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

220.202 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**

B. The date of the request, and the signature of the provider's authorized representative, are required on the form. Stamped and electronic signatures are accepted.

C. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) encounters, use a separate form for each set of encounters.

D. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

E. Enter the procedure code, modifier(s) (when applicable) and a brief narrative description of the procedure.

F. Enter the number of units (encounters) requested under the extension.

220.203 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and

7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures 7-1-22

A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per SFY, and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. The benefit limits apply to claims payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, Certified Nurse-Midwives (CNMs), Nurse Practitioners (NP), and Ambulatory Surgical Centers (ASCs).

C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.

D. Extension of these benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:

1. Malignant neoplasm (View ICD Codes);
2. HIV infection and AIDS (View ICD Codes);
3. Renal failure (View ICD Codes);
4. Pregnancy* (View ICD Codes): or
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (View ICD OUD Codes) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD (View Laboratory and Screening Codes).

E. *Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)

F. Magnetic Resonance Imaging (MRI) is exempt from the five-hundred-dollar radiology/other services benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)

G. Cardiac catheterization procedures are exempt from the five-hundred-dollar outpatient diagnostic laboratory services benefit limit and the five-hundred-dollar radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiaries' medical record.

H. There are no benefit limits on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and

Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.

215.100 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests to extend benefits for outpatient hospital visits and diagnostic laboratory or X-ray services, including those for fetal ultrasounds and fetal non-stress tests, must be submitted to DHS or its designated vendor.

View or print contact information to obtain instructions for submitting the benefit extension request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. Submit a copy of the Medical Assistance Remittance and Status Report that reflects the claim's denial for exhausted benefits with the request. Do not send a claim.

D. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

E. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.101 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," form (Form DMS-671). View or print Form DMS-671.

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped or electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extensions for more than four (4) procedures, use a separate form for each set of procedures.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.440 CAH Benefit Limits 7-1-22

Inpatient stays, non-emergency outpatient visits, diagnostic laboratory, and radiology/other services in Critical Access Hospitals (CAHs) are subject to the same benefit limits that apply to facilities enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program.

Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

Benefit-limited services that are received in CAHs are counted with benefit-limited services received in hospitals enrolled in the Arkansas Medicaid Hospital Program and the Arkansas Medicaid Rehabilitative Hospital Program to calculate a Medicaid-eligible individual's benefit status.

217.141 Computed Tomographic Colonography (CT Colonography) 7-1-22

A. The procedure codes in the link below are covered for computed tomographic (CT) colonography for beneficiaries of all ages.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. CT colonography policy and billing:

1. Virtual colonoscopy, also known as CT colonography, utilizes helical-computed tomography of the abdomen and pelvis to visualize the colon lumen, along with 2D or 3D reconstruction. The test requires colonic preparation similar to that required for standard colonoscopy (instrument/fiberoptic colonoscopy) and air insufflation to achieve colonic distention.

2. Indications: Virtual colonoscopy is only indicated in those patients in whom an instrument/fiberoptic colonoscopy of the entire colon is incomplete due to an inability to pass the colonoscopy proximately. Failure to advance the colonoscopy may be secondary to a neoplasmic or spasmic obstruction, a redundant colon, diverticulitis extrinsic compression, or aberrant anatomy/scarring from prior surgery. This is intended for use in pre-operative situations when knowledge of the unvisualized

colon (proximal to the obstruction) would be of use to the surgeons in planning the operative approach to the patient.

3. Limitations:

   a. Virtual colonography is not reimbursable when used for screening or in the absence of any signs indicating symptoms of disease, regardless of family history or other risk factors for the development of colonic disease.

   b. Virtual colonography is not reimbursable when used as an alternative to instrument/fiberoptic colonoscopy, for screening, or in the absence of signs or symptoms of disease.

   c. Since any colonography with abnormal or suspicious findings would require a subsequent instrument/fiberoptic colonoscopy for diagnosis (such as a biopsy) or for treatment (such as a polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even if performed for signs or symptoms of disease.

   d. CT colonography procedure codes are counted against the beneficiary's benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) for radiology/other services. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

   e. "Reasonable and necessary" services should only be ordered or performed by qualified personnel.

   f. The CT colonography final report should address all structures of the abdomen afforded review in a regular CT of abdomen and pelvis.

C. Documentation requirements and utilization guidelines:

1. Each claim must be submitted with ICD codes that reflect the condition of the patient and indicate the reason(s) for which the service was performed. ICD codes must be coded to the highest level of specificity or claims submitted with those ICD codes will be denied;

2. The results of an instrument/fiberoptic colonoscopy that was performed before the virtual colonoscopy (CT colonography), if the virtual colonoscopy (CT colonography) was incomplete, must be retained in the patient's record; and

3. The patient's medical record must include the following and be available upon request:

   a. The order or prescription from the referring physician;

   b. Description of polyps and lesion:

      i. Lesion size for lesions 6 mm or larger, the single largest dimension of the polyp (excluding stalk if present) on either multiplanar reconstruction or 3D views, and the type of view employed for measurement should be stated;

      ii. Location (standardized colonic segmental divisions: rectum, sigmoid colon, descending colon, transverse colon, ascending colon, and cecum);

      iii. Morphology (sessile-broad-based lesion whose width is greater than its vertical height; pedunculated-polyp with separate stalk; or flat-polyp with vertical height less than 3 mm above surrounding normal colonic mucosa);

      iv. Attenuation (soft-tissue attenuation or fat);

   c. Global assessment of the colon (C-RADS categories of colorectal findings):

      i. C0 – Inadequate study
      poor prep (can't exclude > 10 lesions);

      ii. C1 – Normal colon or benign lesions

no polyps or polyps ≥5 mm
benign lesions (lipomas, inverted diverticulum);

iii. C2 – Intermediate polyp(s) or indeterminate lesion
polyps 6-9 mm in size, <3 in number
indeterminate findings;

iv. C3 – Significant polyp(s), possibly advanced adenoma(s)
Polyps ≥10 mm
Polyps 6-9 mm in size, ≥3 in number;

v. C4 – Colonic mass, likely malignant;

d. Extracolonic findings (integral to the interpretation of CT colonography results):

i. E0 – Inadequate Study limited by artifact;

ii. E1 – Normal exam or anatomic variant;

iii. E2 – Clinically unimportant findings (no work-up needed);

iv. E3 – Likely unimportant findings (may need work-up); for example, incompletely characterized lesions, such as hypodense renal or liver lesion;

v. E4 – Clinically important findings (work-up needed), such as solid renal or liver mass, aortic aneurysm, adenopathy; and

e. CT colonography is reimbursable only when performed following an instrument/fiberoptic colonoscopy that was incomplete due to obstruction.

218.250 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services for beneficiaries under twenty-one (21) years of age.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits being exceeded.

2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.

3. With the request, submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services," must be utilized when requesting extended therapy services. View or print Form DMS-671. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable records that support the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the

provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization.

272.435 Tissue Typing 7-1-22

A. Authorized procedure codes are payable for the tissue typing for both the donor and the receiver.

View or print the procedure codes for Hospital/Critical Access Hospitals/ESRD services.

B. The tissue typing is subject to the following benefit limits:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30);
2. Extensions will be considered for beneficiaries who exceed the five-hundred-dollar benefit limit for diagnostic laboratory services; and
3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue-typing diagnostic laboratory procedures to determine a match for an unrelated bone marrow donor.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
2. All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollar ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services for beneficiaries twenty-one (21) years of age and older. Exceptions are listed below:

1. There is no diagnostic laboratory services benefit limit or radiology/other services benefit limit for beneficiaries under twenty-one (21) years of age.
2. There is no benefit limit on diagnostic laboratory services related to family planning. (Refer to Section 252.431 of this manual for the family planning-related clinical laboratory procedures.)
3. There are no benefit limits on diagnostic laboratory services or radiology/other services that are performed as emergency services and approved by DHS or its designated vendor for payment as emergency services.

   View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.
4. Claims with the following primary diagnoses are exempt from diagnostic laboratory services or radiology/other services benefit limits:
   a. Malignant Neoplasm (View ICD Codes);
   b. HIV disease and AIDS (View ICD Codes);
   c. Renal failure (View ICD Codes);
   d. Pregnancy* (View ICD Codes); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (View ICD OUD Codes.) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (View Laboratory and Screening Codes.)

C. *Obstetric (OB) ultrasounds and fetal non-stress tests have benefit limits and are not exempt from Extension of Benefits request requirements. (See Section 214.630 for additional coverage information.)

D. Extension of benefit requests are considered for clients who require supportive treatment, such as dialysis, radiation therapy, or chemotherapy for maintaining life.

E. Benefits may be extended for other conditions documented as medically necessary.

214.900 Procedures for Obtaining Extension of Benefits 7-1-22

A. Nurse practitioners who perform diagnostic laboratory services or radiology/other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30) and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request an extension of benefits for diagnostic laboratory services or radiology/other services, use the following procedures.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

B. Requests for extension of benefits for diagnostic laboratory services or radiology/other services must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's five-hundred-dollar benefit limit for either diagnostic laboratory services or radiology/other services is exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of benefit limit denial.

D. Additional information will be requested, as needed, to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests do not constitute documentation or proof of timely claim filing.

214.920 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology/Other Services." 7-1-22

A. The Medicaid Program's diagnostic laboratory services limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (such as physician's visits or Nurse Practitioner visits), outpatient services (meaning, hospital outpatient visits), diagnostic laboratory services (meaning, laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). **View or print Form DMS-671.**
2. Complete instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in **Section V** of each provider manual.

214.930 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG)
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must:*
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;

d. Include related diabetic and blood pressure flow sheets;

e. Include a current medication list for the date of service;

f. Include the obstetrical record related to a current pregnancy when applicable; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

2. Diagnostic laboratory and radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests when applicable.

TOC required

225.100 Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit, each applies to the outpatient setting.

1. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG).
2. All benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Medicaid established a maximum amount (benefit limit) of five hundred dollars ($500) per SFY for diagnostic laboratory services and five hundred dollars ($500) per SFY for radiology/other services, for clients twenty-one (21) years of age.

1. There are no laboratory or radiology/other benefit limits for clients under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.
2. There is no benefit limit on professional components of laboratory or radiology/other services for hospital inpatient treatment.
3. There is no benefit limit on laboratory services related to family planning. See Section 292.552 for the family-planning-related clinical laboratory procedures exempt from the laboratory services benefit limit.
4. There is no benefit limit on laboratory services or radiology/other services performed as emergency services.

C. Extension-of-benefit requests are considered for medically necessary services.

1. Claims with any of the following primary diagnoses are exempt from laboratory services or radiology/other benefit limits:
   a. Malignant neoplasm (View ICD Codes);
   b. HIV infection and AIDS (View ICD Codes);
   c. Renal failure (View ICD Codes);
   d. Pregnancy (View ICD Codes); or
   e. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT) (View ICD OUD Codes). Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD. (View Laboratory and Screening Codes).
2. Benefits may be extended for other conditions based on documented reasons of medical necessity. Providers may request extensions of benefits according to instructions in Section 229.100 of this manual.

D. Magnetic resonance imaging (MRI) services are exempt from the five-hundred-dollar ($500) outpatient radiology/other benefit limit. Medical necessity for each MRI must be documented in the client's medical record.

E. Cardiac catheterization procedures are exempt from the five-hundred-dollar ($500) SFY benefit limit (each) for outpatient laboratory services and for radiology/other services. Medical necessity for each procedure must be documented in the client's medical record.

229.100 Extension of Benefits for Diagnostic Laboratory and Radiology/Other, Physician Office, and Outpatient Hospital Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for diagnostic laboratory, radiology/other, physician office, and outpatient services must be submitted to Department of Human Services (DHS) or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.

C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

229.110 Completion of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services, and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). View or print Form DMS-671.
2. Instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

229.120 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records *must*:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, or emergency room records (as applicable) for dates of service in chronological order;
   d. Include related diabetic and blood pressure flow sheets;
   e. Include a current medication list for the date of service;
   f. Include the obstetrical record related to a current pregnancy (when applicable); and
   g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
2. Diagnostic laboratory and radiology/other reports *must* include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

229.210 Process for Requesting Extended Therapy Services 7-1-22

A. Requests for extended therapy services for clients under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extended therapy services.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support the request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671 ("Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services") must be utilized when a person is requesting extended therapy services. View or print Form DMS-671. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the client when a request is denied. Approved requests will be returned to the provider with information specific to the approval.

292.831 Billing for Tissue Typing 7-1-22

A. Authorized procedure codes are payable for tissue typing, both for the donor and the receiver.

B. The tissue typing is subject to the following benefit limit:

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30).
2. Extensions will be considered for individuals who exceed the five-hundred-dollar ($500.00) benefit limit for diagnostic laboratory services.
3. Providers must request an extension.

C. Medicaid will authorize up to ten (10) tissue typing procedures to determine a match for an unrelated donor for a bone marrow transplant.

D. A separate claim must be filed for the tissue typing.

E. Claims for the donor must be forwarded to the Transplant Coordinator.

TOC required

214.300 Diagnostic Laboratory and Radiology/Other Services 7-1-22

A. Diagnostic laboratory services and radiology/other services provided by a podiatrist will be included in the benefit limits for outpatient diagnostic laboratory services and outpatient radiology/other services for individuals twenty-one (21) years of age and over.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. There are no benefits limit for individuals under twenty-one (21) years of age, except for the limitations on fetal echography (ultrasound) and fetal non-stress tests.

C. Benefit extensions may be granted in cases of documented medical necessity.

D. Section 242.130 contains procedure codes payable for diagnostic laboratory and radiology/other services.

215.000 Extension of Benefits 7-1-22

Benefit extensions may be requested in the following situations:

A. Extension of Benefits for Medical Visits;

1. Extensions of benefits may be requested for medical visits that exceed the two (2) visits per State Fiscal Year (SFY: July 1 through June 30) for individuals twenty-one (21) years of age and over with documented medical necessity provided along with the request.

B. Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services;

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

4. Extension of the benefits limit for diagnostic laboratory and radiology/other services may be granted for individuals twenty-one (21) years of age and over when documented to be medically necessary.

C. The Arkansas Medicaid Program exempts the following diagnoses from the extension of benefit requirements when the diagnosis is entered as the primary diagnosis:

1. Malignant Neoplasm (View ICD codes);
2. HIV Infection, including AIDS (View ICD codes);
3. Renal failure (View ICD codes);
4. Pregnancy (View ICD Codes); and
5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). (View ICD OUD Codes) Designated diagnostic laboratory tests will be exempt from the diagnostic laboratory services benefit limit when the diagnosis is OUD. (View Laboratory and Screening Codes).

TOC required

214.000 Benefit Limits 7-1-22

A. Payments for portable X-ray services claims are applied to the radiology/other services benefit limit of five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30).

B. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

C. Beneficiaries under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, do not have benefit limits for portable x-ray services.

214.100 Extension of Benefits for Portable X-Ray Services 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for Portable X-ray services must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for x-ray services.

1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
2. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits. Do not send a claim.

C. Benefit extension requests must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.

E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

214.110 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (diagnostic laboratory tests) and radiology/other services must be submitted to DHS or its designated vendor.

View or print DHS or its designated vendor contact information for extension of benefits for how to obtain information regarding submission processes.

1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory and Radiology Other Services" form (Form DMS-671). **View or print Form DMS-671.**
2. Instructions for accurate completion of Form DMS- 671 (including indication of required attachments) accompany the form. All forms are listed and accessible in Section V of each Provider Manual.

214.120 Documentation Requirements for Extension of Benefits Request 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:
   a. Be legible and include records supporting the specific request;
   b. Be signed by the performing provider;
   c. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);
   d. Include related diabetic and blood pressure flow sheets;

e. Include current medication list for the dates of service;

f. Include obstetrical record related to current pregnancy; and

g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

2. Radiology/other reports *must* include:

a. Clinical indication for diagnostic laboratory and radiology/other services ordered;

b. Signed orders for diagnostic laboratory and radiology/other services;

c. Results signed by the performing provider; and

d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

TOC required

215.120 Benefit Extension Requests 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests to extend benefits for outpatient rehabilitative hospital visits. diagnostic laboratory services, and radiology/other services must be mailed to DHS or its designated vendor.

View or print contact information for how to submit the request.

Benefit extension requests are considered only after a claim has been filed and denied because the benefit is exhausted.

C. A copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits must accompany the request for review. Do not send a claim.

D. Additional information needed to process a benefit extension may be requested from the provider. Failures to provide requested additional information within the specified timeline will result in technical denials, reconsiderations of which are not available.

E. A benefit extension request must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.

F. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests does not constitute documentation or proof of timely claim filing.

215.121 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit, and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Consideration of requests for benefit extensions requires correct completion of all fields of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services." View or print Form DMS-671.

C. The request date and the signature of the provider's authorized representative are required on the form. Both stamped and electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extension for more than four (4) encounters, use a separate form for each set of encounters.

E. Enter a valid ICD diagnosis code and brief narrative description of the diagnosis.

F. Enter a valid revenue code or procedure code (and modifiers, when applicable) and a brief narrative description of the procedure.

G. Enter the number of units of service requested under the extension.

215.122 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for the dates of service (in chronological order);
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include the obstetrical record related to current pregnancy (if applicable); and
7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and

4. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests if applicable.

216.112 Process for Requesting Extended Therapy Services for Beneficiaries Under Twenty-One (21) Years of Age 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age must be submitted to DHS or its designated vendor.

View or print contact information for how to submit the request.

The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied due to regular benefits exceeded.
2. The request must be received within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial with the request. Do not send a claim.

B. Form DMS-671 "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services", must be utilized for requests for extended therapy services. View or print Form DMS-671. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request must be attached.

C. DHS or its designated vendor will approve, deny, or ask for additional information within thirty (30) calendar days of receiving the request. Reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number.

TOC required

218.311 Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services, Form DMS-671 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Benefit extension requests will be considered only when the provider has correctly completed all applicable fields of the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form. (Form DMS-671). **View or print Form DMS-671.**

C. The date of the request and the signature of the provider's authorized representative are required on the form. Stamped and electronic signatures are accepted.

D. Dates of service must be listed in chronological order on Form DMS-671. When requesting benefit extension for more than four (4) encounters, use a separate form for each set of encounters.

E. Enter a valid ICD diagnosis code and a brief narrative description of the diagnosis.

F. Enter the revenue code, modifier(s) when applicable and the applicable nomenclature.

G. Enter the number of units (encounters) requested under the extension.

218.312 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. Records supporting the medical necessity of extended benefits must be submitted with benefit extension requests and requests for reconsideration of denied benefit extension requests.

C. Clinical records must:

1. Be legible and include records supporting the specific request;
2. Be signed by the performing provider;
3. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
4. Include related diabetic and blood pressure flow sheets;
5. Include current medication list for date of service;
6. Include obstetrical record related to current pregnancy when applicable; and
7. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

D. Diagnostic laboratory and radiology/other reports must include:

1. Clinical indication for diagnostic laboratory and radiology/other services ordered;
2. Signed orders for diagnostic laboratory and radiology/other services;
3. Results signed by the performing provider; and
4. Current and all previous ultrasound reports, including biophysical profiles, and fetal non-stress tests (if applicable)

TOC not required

216.300 Process for Requesting Extended Therapy Services 7-1-22

A. Requests for extended therapy services for beneficiaries under twenty-one (21) years of age and adults receiving services in an Adult Developmental Day Treatment (ADDT) must be sent to Arkansas Medicaid's Quality Improvement Vendor (QIO). **View or print the QIO contact information.** The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests for extended therapy services are considered only after a claim is denied because a benefit is exceeded.
2. The request must be received by the QIO within ninety (90) calendar days of the date of the benefits-exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits-exceeded denial appears.
3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's benefits-exceeded denial. Do not send a claim.
4. The QIO will not accept requests sent via electronic facsimile (FAX) or e-mail.

B. Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services", must be utilized for requests for extended therapy services. **View or print Form DMS-671**. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, including credentials, and date the request form. An electronic signature is accepted, provided it complies with Arkansas Code Annotated §25-31-103. All applicable documentation that supports the medical necessity of the request should be attached.

TOC required

216.210 Completion of Form DMS-671, "Request For Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

View or print the essential health benefit procedure codes.

B. Requests for extension of benefits for clinical services (physician's visits) outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.

View or print contact information to obtain instructions for submitting the request.

1. Requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). View or print Form DMS-671.

2. **Instructions for accurate competition of Form DMS-671 (including indication of required attachments) accompany the Form. All forms are listed and accessible in Section V of each provider manual.**

216.220 Documentation Requirements 7-1-22

A. The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

1 Diagnostic laboratory services benefits are limited to five hundred dollars ($500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars ($500) per SFY.

2 Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).

3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

B. To request extension of benefits for any services with benefit limits, all applicable records that support the medical necessity of extended benefits are required.

C. Documentation requirements are as follows.

1. Clinical records must:

a. Be legible and include records supporting the specific request;
b. Be signed by the performing provider;
c. Include clinical, outpatient, and emergency room records for dates of service in chronological order;
d. Include related diabetic and blood pressure flow sheets;
e. Include current medication list for date of service;
f. Include the obstetrical record related to the current pregnancy; and
g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.

2. Diagnostic laboratory and radiology/other reports must include:
   a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
   b. Signed orders for diagnostic laboratory and radiology/other services;
   c. Results signed by performing provider; and
   d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests.

State of Arkansas *As Engrossed: S4/5/21*
93rd General Assembly **A Bill**
Regular Session, 2021 SENATE BILL 395

By: Senator Irvin
By: Representatives M. Gray, D. Ferguson

For An Act To Be Entitled

AN ACT TO MODIFY THE ANNUAL CAP ON DIAGNOSTIC LABORATORY SERVICES IN THE ARKANSAS MEDICAID PROGRAM; AND FOR OTHER PURPOSES.

Subtitle

TO MODIFY THE ANNUAL CAP ON DIAGNOSTIC LABORATORY SERVICES IN THE ARKANSAS MEDICAID PROGRAM.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-140. Diagnostic laboratory services.

(a) The General Assembly finds that:

(1) The national coronavirus 2019 (COVID-19) emergency has emphasized the critical importance of laboratory testing for diagnosing disease and promoting health;

(2) There is a disparity in the scope of laboratory testing services that are covered by the Arkansas Medicaid Program;

(3) Often, radiology services are grouped with diagnostic laboratory services;

(4) Radiology services are more expensive than diagnostic laboratory services and greatly reduce the services that a beneficiary can receive;

(5) The Arkansas Medicaid Program only covers up to five hundred

dollars ($500) for all diagnostic laboratory services, including radiology; and

(6) This disparity in services should be reduced or eliminated.

(b) The program shall set the annual cap for:

(1) Diagnostic laboratory services, not including radiology services, of at least five hundred dollars ($500); and

(2) Radiology services of at least five hundred dollars ($500).

(c) Any laboratory or diagnostic procedure that is an essential health benefit does not count towards the caps described in subsection (b) of this section.

(d) The Department of Human Services shall apply for any federal waiver, Medicaid state plan amendment, or other authorization necessary to implement this section.

/s/Irvin

APPROVED: 4/25/21