SECTION II - AMBULATORY SURGICAL CENTER

CONTENTS

200.000 AMBULATORY SURGICAL CENTER GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Ambulatory Surgical Centers (ASCs)

201.100 Participation Requirements for ASCs in Arkansas 11-1-07

Ambulatory Surgical Center (ASC) providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. An ASC in Arkansas must be licensed by the Arkansas Department of Health as an Ambulatory Surgical Center.

A copy of the ASC's current license must accompany the provider application and Medicaid contract.

B. An ASC must have CMS approval (following certification and recommendation by the State Survey Agency) to participate as a Title XVIII (Medicare) provider.

1. Proof of the ASC's current CMS approval to participate in Medicare must accompany a provider application and a Medicaid contract.
2. To continue its Medicaid enrollment, an ASC must maintain its CMS approval to participate in Medicare.
    a. The State Survey Agency periodically performs recertifications and forwards its certification and recommendation to its CMS Regional Office.
    b. To remain enrolled in Arkansas Medicaid, an ASC must ensure that Arkansas Medicaid's Provider Enrollment Unit has on file at all times (submitted within 30 days of issuance) a copy of the ASC's most recent CMS approval to participate in Medicare.
    c. Retraction or denial of CMS approval to participate in Medicare automatically terminates a provider's Arkansas Medicaid enrollment.

201.101 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.200 Arkansas Medicaid Participation Requirements for ASCs in Bordering-State Trade-Area Cities 11-1-07

A. An ASC in a bordering-state trade area city (limited to Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff and Springfield, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas) must be licensed as an Ambulatory Surgical Center by the appropriate licensing agency within its home state.

A copy of the ASC's current state license must accompany the provider application and Medicaid contract.

B. A trade area city ASC must have CMS approval (following certification and recommendation by its State Survey Agency) to participate as a Title XVIII (Medicare) provider.

1. Proof of the ASC's current CMS approval to participate in Medicare must accompany a provider application and a Medicaid contract.
2. To continue its Medicaid enrollment, an ASC must maintain its CMS approval to participate in Medicare.
    a. State Survey Agencies periodically perform recertifications and forward their certifications and recommendations to their CMS Regional Office.
    b. To remain enrolled in Arkansas Medicaid, an ASC must ensure that Arkansas Medicaid's Provider Enrollment Unit has on file at all times (submitted within 30 days of issuance) a copy of the ASC's most recent CMS approval to participate in Medicare.

c. Retraction or denial of CMS approval to participate in Medicare automatically terminates a provider's Arkansas Medicaid enrollment.

201.300 Bordering-State ASCs Not Located in Trade Area Cities 11-1-07

Bordering-state ASCs that are not in any of the specified trade area cities may not enroll in Arkansas Medicaid.

201.400 ASCs in States not Bordering Arkansas 11-1-07

ASCs in states that do not border Arkansas may not enroll in Arkansas Medicaid.

202.000 Reserved 11-1-09

210.000 PROGRAM COVERAGE

210.100 Introduction 11-1-07

The Medical Assistance (Medicaid) Program helps eligible beneficiaries obtain medical care within the guidelines specified in Section I of this manual. Coverage of Medicaid benefits is based on medical necessity. Refer to the Glossary (Section IV) for the Program's definition of medical necessity.

210.200 Definition, Scope and Coverage of Ambulatory Surgical Center (ASC) Services 7-1-14

A. An ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients not requiring hospitalization.

1. Certain surgical or medical procedures may require prior authorization.
2. Certain surgeries may require paper billing with attached documentation.

B. Arkansas Medicaid covers as bundled or global services, CMS-approved outpatient surgeries and ASC facility services (such as the following), that are directly related to the surgeries.

1. Nursing, technician and related services
2. Use of the facilities where the surgical procedures are performed
3. Drugs, biologicals for which separate payment is not allowed
4. Surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the performance of surgical procedures
5. Diagnostic or therapeutic services or items directly related to the performing of a surgical procedure
6. Specimen handling when applicable
7. Administrative, recordkeeping, and housekeeping items and services
8. Materials for anesthesia
9. Supervision of the services of an anesthetist by the operating surgeon
10. CRNA (employee of the ASC)

210.210 Exclusions, Exceptions and Special Conditions

210.211 Facility Service Exclusions 7-1-14

ASC facility services do not include other items and services that are covered under other Medicaid programs, including laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), collection of specimen by venipuncture when the specimen is sent elsewhere for testing, prosthetic devices, ambulance services; leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patient's home.

210.212 Reserved 7-1-14

210.213 Physician Services 11-1-07

The surgical procedures, including all preoperative and post-operative services that are performed by a physician, osteopath, dentist or oral surgeon, are covered under the Arkansas Medicaid Physician Program or the Arkansas Medicaid Dental Program.

210.214 Laboratory, Radiology and Other Diagnostic Procedures 7-1-14

A. Some laboratory, radiology and other diagnostic procedures not directly related to the surgical procedure are eligible for separate reimbursement. See the ASC fee schedule.

B. These diagnostic procedures eligible for separate reimbursement must be billed by the Medicaid-enrolled performing provider.

211.000 Introduction 10-13-03

The Medical Assistance (Medicaid) Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. All Medicaid benefits are based upon medical necessity. Please refer to the Glossary for the definition of “medical necessity.”

212.000 Scope 10-13-03

An Ambulatory Surgical Center is defined as a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization.

Outpatient services performed in an ASC are defined by the Arkansas Medicaid Program as preventive, diagnostic, therapeutic, rehabilitative or palliative services that:

A. Are provided to outpatients;

B. Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients and

C. Except in the case of nurse-midwife services, are furnished by or under the direction of a physician or dentist.

215.000 Benefit Limits

215.100 Outpatient Surgery Benefit Limits 2-1-05

Outpatient surgical procedures are not subject to benefit limits.

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.

215.111 Benefit Limits for Fetal Ultrasound and Fetal Non-Stress Tests 2-1-05

A. Fetal echography (ultrasound) and fetal non-stress tests are limited to 2 each per pregnancy for all ages.

B. Medicaid will consider extending these benefits if the procedures are medically necessary.

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).

215.123 Provider Notification of Benefit Extension Determinations 8-1-21

Approval or denial of a benefit extension request—or request for additional information—will be made within thirty (30) calendar days.

Reviewers will simultaneously advise the provider and the beneficiary when a benefit extension request is denied.

215.124 Administrative Reconsiderations and Appeals 6-1-25

A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.

B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

215.200 Reserved 6-1-25

216.000 Coverage Limitations

216.100 Abortions 10-13-03

Prior authorization is required for all abortions. See Section 221.000 of this manual for instructions for obtaining prior authorization for abortions when the life of the mother would be endangered if the fetus were carried to term. Only medically necessary abortions will be authorized. Federal regulations prohibit expenditures for abortions except when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest as certified in writing by the woman's attending physician.

216.110 Abortion When the Life of the Mother Would be Endangered if the Fetus Were Carried to Term 10-13-03

Providers submitting claims to Medicaid for an abortion procedure when the life of the mother would be endangered if the fetus were carried to term must attach the following information to the claim:

A. A completed Form DMS-2698 (Certification Statement for Abortion). **View or print form DMS-2698.** The DMS-2698 form must include the name and address of the patient and must be dated prior to the date of the surgery.

1. The patient may sign the Certification Statement for Abortion (DMS-2698) for herself at eighteen (18) years of age or older.
2. If a guardian signs the Certification Statement for Abortion (DMS-2698), the guardian must furnish a copy of the order appointing him or her as guardian or the letters of guardianship issued by the court clerk.

B. Patient history and physical examination records.

C. Discharge summary, if available.

The physician performing the abortion is responsible for providing the required documentation to other providers (hospital, anesthetist, etc.) for billing purposes.

216.120 Abortion When the Pregnancy is a Result of Rape or Incest 10-13-03

Follow these procedures for abortions in the case of rape or incest:

A. Patient presents for abortion examination at the provider.

B. Physician makes determination that the pregnancy is the result of rape or incest.

C. Physician completes the certification form (DMS-2698) certifying that the pregnancy resulted from forcibly compelled sexual intercourse or incest as defined under Ark. Code Ann. § 5-14-103 and § 5-22-202.

1. The patient may sign the Certification Statement for Abortion (DMS-2698) for herself at eighteen (18) years of age or older.
2. If a guardian signs the Certification Statement for Abortion (DMS-2698), the guardian must furnish a copy of the order appointing him or her as guardian or the letters of guardianship issued by the court clerk.

D. Physician contacts the Department of Human Services (DHS), Division of Medical Services (DMS), Administrator, Utilization Review, for prior authorization of the abortion procedure as required in the Arkansas Medicaid Physician's Manual. **View or print the Utilization Review contact information.**

E. DHS, DMS notifies the physician within 24 hours of prior approval or if necessary, requests more complete information for the required physician's review.

F. Provider receives approval and performs the procedure.

G. Provider submits the claim and required documentation, including patient history and physical examination records, for payment to the Department of Human Services, Division of Medical Services, Utilization Review unit. **View or print the Utilization Review contact information.** If the documentation is complete with the claim, the DMS Utilization Review nurse will approve for processing. Processing includes determination of Medicaid eligibility and third party availability.

H. DHS, DMS notifies the third party source of prior authorization for the beneficiary.

I. An Explanation of Benefits (EOB) Message will be returned to the provider on their remittance advice, stating that the abortion procedure is covered by a standing third party source, with instruction to seek reimbursement accordingly.

J. Third party source provides payment to the provider. Payment is in accordance with 42 USCA 433.139.

216.121 Procedure Codes for Abortion in the Case of Rape or Incest 7-1-14

See the ASC fee schedule for payable abortion procedure codes in the case of rape or incest.

If the beneficiary requires the Certification Statement for Abortion in an alternative format, such as large print, please contact the Americans with Disabilities Act Coordinator. **View or print the certification form DMS-2698.** **View or print the Americans with Disabilities Act Coordinator contact information.**

216.200 Cosmetic Surgery 10-13-03

Cosmetic surgery is NOT generally covered under the Medicaid Program except in the following areas, and then only after prior authorization has been obtained. (See Section 221.000 of this manual for information related to obtaining prior authorization.)

A. Reduction mammoplasty. Reduction mammoplasty is a covered service under the Medicaid program.

B. Otoplasty (lop ears). Payment will be allowed for surgical correction of lop ears and similar congenital abnormalities when performed on children prior to their 21st birthday. Criteria used in the evaluation of such procedures will include the attending physician's statement as to the degree that such conditions are detrimental to the patient's psychological well-being.

C. Rhinoplasty. Payment will be allowed for surgical correction involving rhinoplasty procedures when performed on children prior to the 21st birthday. Criteria used in the evaluation of such procedures will include the attending physician's statement as to the degree that such conditions are detrimental to the patient's physical and functional abilities.

Expenses incurred for cosmetic surgery other than those listed above will not be covered by the Medicaid Program.

216.300 Sterilizations 10-13-03

Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing and which is not either (1) a necessary part of the treatment of an existing illness or injury or (2) medically indicated as an accompaniment of an operation of the female genitourinary tract. The reason for which the individual decides to take permanent and irreversible action is irrelevant. It may be for social, economic or psychological reasons or because a pregnancy would be inadvisable for medical reasons.

Prior authorization is not required for sterilization. However, all applicable criteria described in this manual must be met.

Only the official sterilization consent form (DMS-615) may be used for compliance with the documentation requirements. **View or print form DMS-615.** An original or copy of the completed form must be submitted with each claim, and a copy must be maintained with the patient's medical records for a minimum of five (5) years.

Medicaid covers sterilization only when the following conditions are met:

A. The person on whom the sterilization procedure is to be performed voluntarily requests such services.

B. The person is mentally and legally competent to give informed consent.

C. The person is 21 years of age or older at the time informed consent is obtained.

D. The person to be sterilized shall not be an institutionalized individual. The regulations define “institutionalized individual” as a person who is (1) involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility including those for a mental illness, or (2) confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

E. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.

F. Such informed consent and counseling are properly documented and submitted with the claim from each provider.

G. Informed consent may not be obtained while the person to be sterilized is:

1. In labor or during childbirth,
2. Seeking to obtain or obtaining an abortion or
3. Under the influence of alcohol or other substances that affect the individual’s state of awareness.

H. Such sterilization is performed at least 30 days, but not more than 180 days, after the date of informed consent. The following are exceptions to the 30-day waiting period:

1. In the case of premature delivery, provided at least 72 hours have passed between giving the informed consent and performance of the sterilization procedure, and counseling and informed consent was given at least 30 days before the expected date of delivery and
2. In the case of emergency abdominal surgery, provided at least 72 hours have passed between giving of informed consent and the performance of the sterilization procedure.

NOTE: Either of these exceptions to the 30-day waiting period must be properly documented on the DMS-615 Consent Form.

I. The original (or a copy in which all items are legible) of the completed consent form (DMS-615) must be attached to each claim submitted from each provider before payment may be approved. Providers include hospitals, ambulatory surgical centers, physicians, anesthesiologists and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the ASC, anesthesiologist and assistant surgeon.

J. The person is informed, prior to any sterilization discussion or counseling, which no benefits or rights will be lost as a result of refusal to be sterilized and that sterilization is an entirely voluntary matter. This should be explained again just prior to the performance of the sterilization.

The responsibility for properly submitting forms rests with the provider.

216.310 Consent to Sterilization – Additional Information 10-13-03

The following is to provide additional information regarding proper completion of the Consent to Sterilization form (DMS-615). Prior authorization is not required. However, an improperly completed consent form results in the delay or denial of payment for the sterilization procedures. The DMS-615 includes a checklist which lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Please use this checklist before submitting any consent form and claim for payment, to be sure that all criteria have been met.

The following general comments concerning sterilization procedures are also provided for your information:

A. Federal regulations are very explicit concerning disallowance of payment for sterilization of a person who is not mentally competent to give informed consent. By signing the consent form, the patient certifies that he or she understands the entire process. By signing the consent form, the person obtaining consent and the physician certify that, to the best of their knowledge, the patient is mentally competent to give informed consent. If any questions concerning this requirement exist, contact the Arkansas Medicaid Program for clarification BEFORE the sterilization procedure is performed.

B. If the patient signs with an “X,” two witnesses must also sign and include a statement regarding the reason the patient signed with an “X,” such as, stroke, paralysis, legally blind, etc.

C. Federal regulations prohibit Medicaid payment for the sterilization of any person who is institutionalized. If there are questions concerning this requirement, contact the Arkansas Medicaid Program BEFORE the sterilization is performed.

D. Informed consent may not be obtained while the person to be sterilized is in labor or during childbirth, seeking to obtain or obtaining an abortion or under the influence of alcohol or other substances that affect the individual’s state of awareness.

E. By signing the physician’s statement on the consent form, the physician is certifying that shortly before the sterilization was performed, he or she again counseled the patient concerning the sterilization procedure. Federal interpretation of this requirement is as follows:

   1. “Within this context, ‘shortly before’ means a period defined by the State which is reasonable in light of the circumstances surrounding the procedure.”
   2. In keeping with this interpretation, the State has defined “shortly before” as one week (seven days) prior to the performance of the sterilization procedure.
   3. The physician’s signature on the consent form must be an original signature and not a rubber stamp.

F. The person obtaining the consent for sterilization must sign and date the form after the beneficiary and interpreter, if one is used. This may be done immediately after the beneficiary’s and interpreter’s signatures, or it may be done at some later time, but always before the sterilization procedure. The signature will attest to the fact that all elements of informed consent were given and understood and that consent was voluntarily given.

G. A copy of the consent form given to the beneficiary of a sterilization procedure must be an identical copy of the one he or she signed and dated and must reflect the signature of the person obtaining the consent.

H. If the patient needs the Consent for Sterilization (Form DMS-615) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator. **View or print Americans with Disabilities Act Coordinator contact information.**

216.400 Family Planning 11-1-17

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

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

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

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

View or print contact information for the Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs.

216.410 Informed Consent for Hysterectomies 7-1-14

Any Medicaid beneficiary who is to receive a hysterectomy, regardless of the diagnosis or the age of the patient, must be informed both orally and in writing that the hysterectomy will render the patient permanently incapable of reproduction. The patient or their representative may receive this information from the individual who secures the usual authorization for the hysterectomy procedure.

The patient or their representative, if any, must sign and date the Acknowledgement of Hysterectomy Information (Form DMS-2606) not more than 180 days prior to the hysterectomy procedure being performed. **View or print form DMS-2606 and instructions for completion.**

216.420 Random Audits of Hysterectomies 10-13-03

All hysterectomies paid for by Federal and State funds will be subject to random selection for post-payment review. At the time of such review, the medical records must document the medical necessity of hysterectomies performed for carcinoma in-situ and severe dysplasia and must contain tissue reports confirming the diagnosis. The tissue must have been obtained prior to surgery.

The medical record of those hysterectomies performed for malignant neoplasms must contain a tissue report confirming such diagnosis. However, the tissue may be obtained during surgery, e.g., frozen sections. Any medical record found on post-payment review which does not contain a tissue report confirming the diagnosis or any medical record found which does not document the medical necessity of performing such surgery will result in recovery of payments made for that surgery.

216.430 Hysterectomies Performed for Sterilization 10-13-03

Medicaid will not pay for any hysterectomy performed for the sole purpose of sterilization.

216.500 Acknowledgement Statement for Hysterectomies and Sterilization Consent Form 7-15-12

The acknowledgement statement for hysterectomies must be signed by the patient or a representative and the sterilization consent form must be signed by the patient. For beneficiaries with physical disabilities, these required statements must be signed by the patient. If the patient signs with an “X,” two witnesses must also sign and include a statement regarding the reason the patient signed with an “X,” such as, stroke, paralysis, legally blind, etc. This procedure is to be used for patients who are not mentally impaired.

For hysterectomies for individuals with intellectual disabilities, the acknowledgement of sterility statement is required. A guardian must petition the court for permission to sign for the patient giving consent for the procedure to be performed. A copy of the court petition and the acknowledgement statement must be attached to the claim. Sterilization procedures for birth control purposes are not covered for the mentally incompetent.

216.600 Other Covered ASC Services

216.601 Cochlear Implants and External Sound Processors 7-1-14

A. The Arkansas Medicaid Program covers cochlear implantation for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

B. ASC reimbursement is inclusive of the device and accessories; no separate payment is allowed.

216.602 Reserved 7-1-14

216.603 Organ or Disease Oriented Panels 7-1-14

In order to bill for laboratory tests not included in the ASC payment for covered surgical procedures, an ASC's laboratory must be CLIA-certified and enrolled as a laboratory provider.

216.604 Reserved 7-1-14

216.605 Reserved 7-1-14

216.700 Dental Surgery 11-1-07

A. Medicaid covers dental surgery in ASCs.

B. See Section 242.110 for billing instructions.

216.800 Reserved 7-1-14

216.810 Reserved 7-1-14

216.820 Reserved 7-1-14

216.830 Reserved 7-1-14

216.900 Reserved 7-1-14

220.000 PRIOR AUTHORIZATION

221.000 Prior Authorization Information 8-1-21

A. Clinical criteria for prior authorization (PA) must support the medical necessity for the procedure and must be suitable for the diagnosed condition or disorder.

B. DHS or its designated vendor reviews and determines approval or denial for outpatient surgery PA. **View or print contact information for information on how to submit an outpatient surgery PA.**

C. Prior authorization does not guarantee payment: providers must comply with all Medicaid regulations related to the medical service.

Claims for some procedures must be submitted on paper and accompanied by operative reports, consent forms or other documentation and are not accepted electronically or without the required attachments.

221.100 Prior Authorization Request and Notification Procedures 8-1-21

The procedures in this section apply to all requests for prior authorization (PA) of outpatient surgeries.

A. The attending physician or the physician's office nurse (or a licensed physician assistant) must furnish the necessary information to DHS or its designated vendor. **View or print contact information regarding submission processes.**

B. The provider will receive written confirmation of the determination.

When a PA request is denied, the provider and the beneficiary have administrative and legal rights to reconsideration and appeal (explained in Sections 160.000 through 169.000 of the Arkansas Medicaid provider manual).

C. Individual written confirmation is given to the surgeon.

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

221.110 Reserved 7-1-14

A. When an individual becomes Medicaid-eligible retroactively *and* the provider agrees to bill Medicaid, the eligibility authorization date is the date on which an individual is officially determined or declared eligible for a program such as Medicaid, ARKids First-A or ARKids First-B and the eligibility file is activated in Medicaid's computers.

B. When someone becomes eligible retroactively, filing deadlines and other limited periods are calculated from the eligibility authorization date instead of from the date(s) of service.

The eligibility authorization date is seldom the same date as the eligibility segment's effective date.

221.120 When Beneficiary Medicaid Eligibility is Determined Retroactively 7-1-14

A. When an individual becomes Medicaid-eligible retroactively *and* the provider agrees to bill Medicaid, the eligibility authorization date is the date on which an individual is officially determined or declared eligible for a program such as Medicaid, ARKids First-A or ARKids First-B and the eligibility file is activated in Medicaid's computers.

B. When someone becomes eligible retroactively, filing deadlines and other limited periods are calculated from the eligibility authorization date instead of from the date(s) of service.

The eligibility authorization date is seldom the same date as the eligibility segment's effective date.

221.130 Reserved 7-1-14

222.000 ASC Procedures That Require Medical Review, Prior Authorization, and Diagnosis Code Restriction 6-1-20

A. The procedure codes found in the following link require medical review, prior authorization, or diagnosis restriction as of the effective date indicated. **View or print the procedure codes for ASC services**.

B. For dates of service on or after November 1, 2017 the following procedure codes require prior authorization.

Outpatient Surgery Abortion Codes That Require Prior Authorization		
59840	59841	59866

1. Refer to Section 216.110, “Abortion When Life of Mother Would Be Endangered If the Fetus Were Carried to Term,” for the prior authorization process.
2. Refer to Section 216.120, “Abortion When the Pregnancy Is a Result of Rape or Incest,” for the prior authorization process.
3. Abortion claims must be billed on a paper CMS-1450 (UB-04) claim form with the DMS-2698 form (Certification Statement for Abortion), history and physical, and operative report attached. **View a sample CMS-1450 (UB-04) claim form.** **View or print form DMS-2698.**

223.000 Reserved 11-1-17

230.000 REIMBURSEMENT

230.100 Reimbursement 7-1-14

Covered dental surgical procedures in the ASC are assigned to one of four groups for reimbursement purposes. Billing instructions are in Section 242.110.

A. Medicaid has established a maximum allowable fee for each dental surgical group.

1. Reimbursement is the lesser of the billed charge or the maximum allowable fee for the applicable dental surgical group.
2. The maximum allowable fees are global fees that include all of the covered ASC facility services listed in Section 210.200.

B. When multiple surgical procedures are performed on the same date of service, surgical procedures subject to the multiple procedure (MP) discount will be reimbursed in the following manner:

1. The surgical code with the highest reimbursement will be paid at 100%; the 2nd code at 50% if subject to the MP discount and the 3rd code at 50% if subject to the MP discount.
2. Procedures not subject to the MP discount and allowed separate reimbursement will be reimbursed according to the ASC fee schedule.

230.110 ASC Procedures 7-1-14

Covered procedures for ASCs can be found on the ASC fee schedule on the Arkansas Medicaid website.

230.120 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

230.130 Reserved 5-1-07

230.140 Reserved 5-1-07

232.000 Specimen Collection and Handling 7-1-14

There is no separate reimbursement for the collection and handling of specimens.

233.000 Reserved 7-1-14

234.000 Reserved 7-1-14

235.000 Rate Appeal Process 10-13-03

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure, or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Ambulatory Surgical Center providers use the Uniform Billing form CMS-1450 (UB-04) to bill the Arkansas Medicaid Program on paper. Each claim may contain charges for only one (1) beneficiary.

A Medicaid claim may contain only one (1) billing provider's charges for services furnished to only one (1) Medicaid beneficiary.

Section III of this manual contains information regarding available options for electronic claims submission.

All details billed (electronically or on paper) by an ASC provider require the modifier SG, "Ambulatory Surgical Center (ASC) facility service." See Section 242.100 for Dental billing.

National Correct Coding Initiative (NCCI) editing applies to all claim submissions.

Arkansas Medicaid accepts claims that include national modifiers.

242.000 CMS-1450 Billing Procedures for ASCs

242.100 Special Billing

242.110 ASC Dental Billing 7-1-14

Outpatient dental surgical procedures performed in an ASC are billed to Medicaid with revenue codes rather than with HCPCS or CPT procedure codes. Bill Medicaid with the revenue code that is in the same outpatient surgical group as the surgery performed. Modifier SG should **not** be billed with Dental surgery revenue codes below.

Revenue Code	Description
0361	Group I, Outpatient Dental Surgery
0360	Group II, Outpatient Dental Surgery
0369	Group III, Outpatient Dental Surgery
0509	Group IV, Outpatient Dental Surgery

242.120 Pass-Through Device Billing 7-1-14

Pass-through device procedure codes require manual review prior to payment. These procedure codes are to be billed on paper claims with the manufacturer's invoice attached. The pass-through device code and the surgical procedure code must be billed on the same claim.

242.130 Reserved 7-1-14

242.140 Reserved 7-1-14

242.141 Reserved 7-1-14

242.145 Reserved 7-1-14

242.146 Reserved 6-30-11

242.150 Verteporfin (Visudyne) 10-1-15

A. Medicaid reimburses ASCs for Verteporfin (Visudyne), HCPCS procedure code **J3396,** when it is furnished to Medicaid-eligible beneficiaries.

1. Reimbursement for Verteporfin is not included in the reimbursement for the related surgical procedure,
2. Providers may bill Medicaid separate charges for Verteporfin and the related surgical procedure.

B. Claims for Verteporfin administration must include one of the following ICD diagnosis codes. (**View ICD codes.**)

C. Use anatomical modifiers to identify the eye(s) being treated.

D. **J3396** may be billed electronically or on a paper claim.

E. NDC billing protocol must be followed for this drug. See Section 242.400.

242.160 Reserved 7-1-14

242.161 Reserved 7-1-14

242.170 Reserved 6-30-11

242.200 Reserved 7-1-14

242.300 Paper Billing Procedures 11-1-17

Medicaid does not supply providers with Uniform Billing claim forms. Numerous venders sell UB-04 forms. **View a sample CMS-1450 (UB-04) claim form.**

Complete Arkansas Medicaid program claims in accordance the National Uniform Billing Committee UB-04 data element specifications and Arkansas Medicaid's billing instructions, requirements, and regulations.

The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA) and is the official source of information regarding UB-04. **View or print NUBC contact information.**

The committee develops, maintains, and distributes to its subscribers the UB-04 Data Element Specifications Manual and periodic updates. The NUBC is also a vendor of UB-04 claim forms.

Following are Arkansas Medicaid's instructions for completing, in conjunction with the UB-04 Data Element Specifications Manual (UB-04 Manual), a UB-04 claim form.

Please forward the original of the completed form to the Claims Department. **View or print the Claims Department contact information.** One copy of the claim form should be retained for your records.

NOTE: A provider furnishing services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services. The provider is strongly encouraged to print the eligibility verification and retain it until payment is received.

242.310 Billing Instructions – Paper Only 12-15-14

Field #	Field name	Description
1.	(blank)	Enter the provider's name, (physical address – service location) city, state, zip code, and telephone number.
2.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
3a.	PAT CNTL #	The provider may use this optional field for accounting purposes. It appears on the RA beside the letters "MRN." Up to 16 alphanumeric characters are accepted.
3b.	MED REC #	Required. Enter up to 15 alphanumeric characters.
4.	TYPE OF BILL	See the UB-04 manual. Four-digit code with a leading zero that indicates the type of bill.
5.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
6.	STATEMENT COVERS PERIOD	Enter the same date in both sections of the field. Format: MMDDYY.
7.	Not used	Reserved for assignment by the NUBC.
8a.	PATIENT NAME	Enter the patient's last name and first name. Middle initial is optional.
8b.	(blank)	Not required.
9.	PATIENT ADDRESS	Enter the patient's full mailing address. Optional.
10.	BIRTH DATE	Enter the patient's date of birth. Format: MMDDYYYY.
11.	SEX	Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	Not required.
13.	ADMISSION HR	Not required.
14.	ADMISSION TYPE	Not required.
15.	ADMISSION SRC	Not required.
16.	DHR	Not applicable.
17.	STAT	Not applicable.
18.-28.	CONDITION CODES	Required when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Required when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	See the UB-04 Manual.
37.	Not used	Reserved for assignment by the NUBC.

Field #	Field name	Description
38.	Responsible Party Name and Address	See the UB-04 Manual.
39.	VALUE CODES	Not applicable.
a.	CODE	Not applicable.
	AMOUNT	Not applicable.
b.	CODE	Not applicable.
	AMOUNT	Not applicable.
40.	VALUE CODES	Not applicable.
41.	VALUE CODES	Not applicable.
42.	REV CD	Enter a revenue code when applicable. See the UB-04 Manual and this provider manual.
43.	DESCRIPTION	See the UB-04 Manual. Required for paper claims only.
44.	HCPCS/RATE/HIPPS CODE	Enter a surgery or diagnostic procedure code.
45.	SERV DATE	Each procedure code or revenue code requires a date of service in this field. Date format: MMDDYY.
46.	SERV UNITS	Enter the applicable number of units.
47.	TOTAL CHARGES	Enter the product of the charge per unit times the number of units.
48.	NON-COVERED CHARGES	Not applicable.
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Line A is required. See the UB-04 for additional regulations.
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number..
52.	REL INFO	Required. See the UB-04 Manual.
53.	ASG BEN	Required. See “Notes” at field 53 in the UB-04 Manual.
54.	PRIOR PAYMENTS	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do **not** include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
55.	EST AMOUNT DUE	Situational. See the UB-04 Manual.
56.	NPI	Enter NPI of billing provider or enter the Medicaid ID.
57.	OTHER PRV ID	Not required.
58. A, B, C	INSURED’S NAME	Comply with the UB-04 Manual’s instructions.

Field #	Field name	Description
59. A, B, C	P REL	Not applicable. Comply with the UB-04 Manual's instructions when there are other payers.
60. A, B, C	INSURED'S UNIQUE ID	Enter the patient's Medicaid identification number on the first line of the field.
61. A, B, C	GROUP NAME	Not applicable. See UB-04 Manual when there are other payers.
62. A, B, C	INSURANCE GROUP NO	When applicable, follow instructions for fields 60 and 61.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Enter any applicable prior authorization or benefit extension number in field 63A.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	When applicable, based upon fields 51 through 62, enter the name(s) of the individuals and entities that provide health care coverage for the patient (or may be liable).
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67. A-H	(blank)	Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received. Fields are available for up to 8 codes.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Not applicable.
70.	PATIENT REASON DX	Not applicable.
71.	PPS CODE	Not required.
72	ECI	See the UB-04 Manual. Required when applicable (for example, TPL and torts).
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI	Enter NPI of the primary attending physician or enter the Medicaid ID.

Field #	Field name	Description
	QUAL	Not required.
	LAST	Enter the surgeon's last name.
	FIRST	Enter the surgeon's first name.
77.	OPERATING NPI	NPI is not required.
	QUAL	Not applicable.
	LAST	Not applicable.
	FIRST	Not applicable.
78.	OTHER NPI	NPI is not required.
	QUAL	Enter 0B, indicating state license number. Enter the referring physician's state license number in the second part of the field.
	LAST	Enter the referring physician's last name.
	FIRST	Enter the referring physician's first name.
79.	OTHER NPI/QUAL/LAST/FIRS	Not used.
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.

242.400 Drug Procedure Codes and National Drug Codes (NDCs) 1-1-23

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on or after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Arkansas Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A "covered labeler" is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the **DHS contracted Pharmacy vendor** website.

A complete listing of **"Covered Labelers"** is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no

longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the NDC termination date. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer/distributor.

Arkansas Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA-assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the “5-4-2” format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected/denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	1234567890**0**1
1111-2222-33	**0**1111222233
01111 456 71	01111**0**45671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected/denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

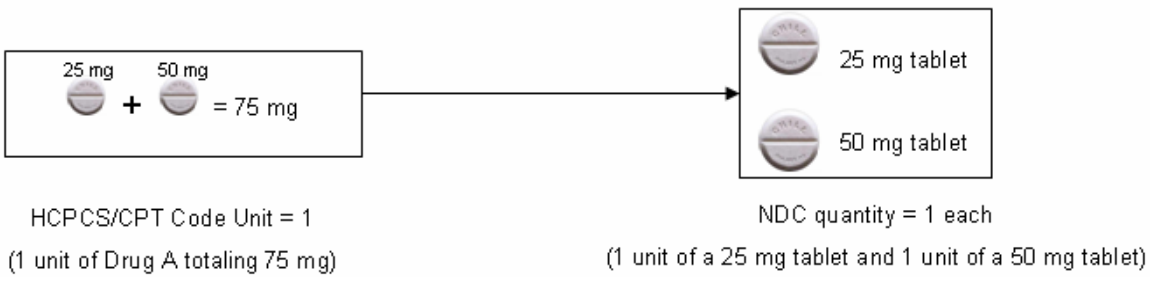
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

C. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

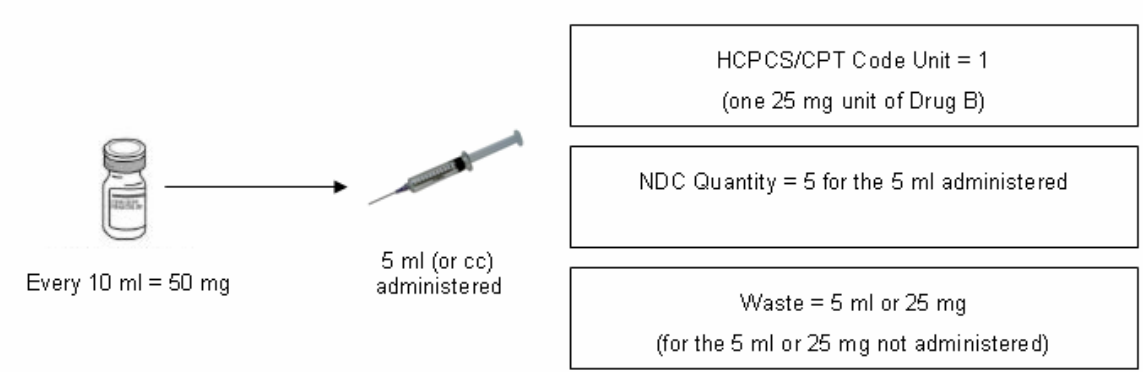
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug, whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC quantity would be 1 each (1 unit of the 25 mg tablet and 1 unit of the 50 mg tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of 5 ml (or cc) of a product that was 50 mg per 10 ml of a 10 ml single-use vial, the HCPCS/CPT code unit would be 1 (1 unit of 25 mg) whereas the NDC quantity would be 5 (5 ml). In this example, 5 ml or 25 mg would be documented as wasted. See Diagram 5. For billing wastage, see bullets D (Electronic Claims Filing) and E (Paper Claims Filing) below.

Diagram 5



D. Electronic Claims Filing 837I (Outpatient)

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – submit via paper claim
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

E. Paper Claims Filing CMS-1450 (UB-04)

Providers are instructed to bill as follows:

- 1 NDC for a procedure – 1st/only detail shall be billed with no modifier
- 2 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

Diagram 6

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0636	N4 12345678912 UN 1.00	Z1234 KP	01/01/22	1	2500		
0636	N4 01111222233 UN 1.00	Z1234 KQ	01/01/22	1	2500		
0636	N4 44444455506 ML 3.00	Z1234 KQ	01/01/22	3	7500		
0636	N4 44444455506 ML 2.00	Z1234 JW	01/01/22	2	5000		

F. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

G. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, disputes or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC invoices showing the purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

242.410 Billing of Multi-Use and Single-Use Vials 1-1-23

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges 96365 through 96379.

B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.