SECTION II - PHYSICIAN/INDEPENDENT LAB/CRNA/RADIATION THERAPY CENTER

CONTENTS

292.593 Reserved
292.594 Reserved
292.595 Special Pharmacy, Therapeutics and Radiopharmaceutical Therapy and Treatments
292.599 New Pharmacy Therapeutics
292.600 Laboratory and X-Ray Services
292.601 Organ or Disease Oriented Panels
292.602 Special Billing Requirements for Lab and X-Ray Services
292.603 Billing Protocol for Computed Tomographic Colonography (CT)
292.610 Magnetic Resonance Imaging (MRI)
292.620 Office Medical Supplies - Beneficiaries Under Age 21
292.630 Medicare
292.631 Services Prior to Medicare Entitlement
292.632 Services Not Medicare Approved
292.640 Multiple Surgery
292.650 NeuroCybernetic Prosthesis
292.660 Newborn Care
292.670 Obstetrical Care
292.671 Method 1 - “Global” or “All-Inclusive” Rate
292.672 Method 2 - “Itemized Billing”
292.673 Fetal Non-Stress Test and Ultrasound
292.674 External Fetal Monitoring
292.675 Obstetrical Care Without Delivery
292.676 Risk Management for Pregnancy
292.680 Outpatient Hospital Services
292.681 Emergency Services
292.682 Non-Emergency Services
292.683 Therapy and Treatment
292.684 Outpatient Hospital Surgical Procedures
292.690 Pelvic Examinations, Prostatic Massages, Removal of Sutures, Etc.
292.700 Physical and Speech-Language Therapy Services Billing
292.710 Prior Authorization Control Number
292.720 Billing for Professional Component of Services Performed in a Hospital
292.730 Professional and Technical Components
292.740 Counseling Services
292.741 Behavioral Health Screen
292.742 Family/Group Psychotherapy
292.750 Radiation Therapy
292.760 Rural Health Clinic (RHC) Non-Core Services
292.770 Sexual Abuse Examination for Beneficiaries 0 - 20 Years
292.780 Locum Tenens and Substitute Physician Policy
292.790 Surgical Procedures with Certain Diagnosis Ranges
292.801 Cochlear Implant and External Sound Processor Billing Protocol
292.810 Reserved
292.811 Reserved
292.812 Reserved
292.813 Reserved
292.820 Organ Transplant Billing
292.821 Billing for Corneal Transplants
292.822 Billing for Renal (Kidney) Transplants
292.823 Billing for Pancreas/Kidney Transplants - Under Age 21
292.824 Billing for Bone Marrow Transplants
292.825 Billing for Heart Transplants
292.826 Billing for Liver Transplants
292.827 Billing for Liver/Bowel Transplants
292.828 Billing for Lung Transplants
292.829 Reserved
292.830 General Information for Transplants

200.000 PHYSICIAN/INDEPENDENT LAB/CRNA/RADIATION THERAPY CENTER GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements 10-1-06

Each provider type whose services are included in this manual 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.

201.100 Arkansas Medicaid Participation Requirements for Physicians 2-1-06

All physicians are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

A. A provider of physician's services must be licensed to practice in his or her state.

B. A provider of physician's services (with the exception of a pediatrician) must be enrolled in the Title XVIII (Medicare) Program.

C. A copy of the following documents must accompany the application and contract:

1. The physician must submit a copy of his or her current license to practice in his or her state.

2. Out-of-state physicians must submit a copy of verification that reflects current enrollment in the Title XVIII (Medicare) Program.

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.

201.110 Group Providers of Physician Services 10-13-03

Group providers of physician services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a physician is a member of a group of physicians, each individual physician and the group must both enroll according to the following criteria:

A. Each individual physician within the group must enroll following the criteria established in Section 201.100.

The group must complete an application and contract as an Arkansas Medicaid provider of physician services and must be approved by the Arkansas Medicaid Program.

B. The group must also be enrolled in the Title XVIII (Medicare) program. Out-of-state providers must submit proof of current Medicare enrollment.

C. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled licensed physician within the group

201.111 Arkansas Medicaid Participation Requirements for Rural Health Clinic or Federally Qualified Health Clinic Physician Groups 10-13-03

Physicians contracting with a rural health clinic (RHC) or a Federally Qualified Health Clinic (FQHC) may bill for RHC or FQHC non-core services **only** as a physician group provider. The following criteria must be met in order to be eligible for participation in the Arkansas Medicaid Program:

A. Each individual physician and the group must enroll following the criteria established in Sections 201.100 and 201.110 of this manual.

B. The group must enroll as an Arkansas Medicaid provider of physician services.

C. Each individual physician in the group must provide three (3) copies of his or her contract with the rural health clinic to be submitted with the Medicaid application and contract.

D. The Arkansas Medicaid Program must approve the group application and contract.

201.120 Physicians in Arkansas and Bordering States 12-15-14

Physicians in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as a **routine services provider** if they meet all Arkansas Medicaid participation requirements outlined in Section 201.100.

Routine services providers may be enrolled in the program as providers of "routine services." Reimbursement may be available for all physician services covered in the Arkansas Medicaid Program. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.130 Providers of Physician Services in States Not Bordering Arkansas 9-15-12

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website, and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print the Provider Enrollment Unit contact information**.

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.

3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.200 Arkansas Medicaid Participation Requirements for Independent Laboratories 2-1-06

All Independent Laboratories are eligible for participation in the Arkansas Medicaid Program if they meet the following criteria:

A. A provider of Independent Laboratory services must be registered and have been issued a certificate and identification number under the Clinical Laboratory Improvement Amendment (CLIA) of 1988. If you need information on the Centers for Medicare and Medicaid Services (CMS) CLIA program, please contact the Arkansas Department of Health Division of Health Facility Services. **View or print the Arkansas Department of Health Division of Health Facility Services contact information.**

B. The Independent Laboratory must be certified as a Title XVIII (Medicare) provider in its home state.

C. A copy of the CLIA certificate and a copy of the current Title XVIII (Medicare) certification must accompany the provider application and Medicaid contract.

D. Out-of-state laboratories must verification of current Title XVIII (Medicare) Program certification.

201.210 Independent Laboratories in Arkansas, Bordering and Non-Bordering States 12-15-14

Independent Laboratories in Arkansas, the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) and non-bordering states may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements outlined above.

Reimbursement may be available for all independent laboratory services covered in the Arkansas Medicaid Program. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.300 Arkansas Medicaid Participation Requirements for Certified Registered Nurse Anesthetist (CRNA) 2-1-06

Providers of Certified Registered Nurse Anesthetist (CRNA) services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. A provider of CRNA services must be currently licensed as a Certified Registered Nurse Anesthetist in his/her state and be nationally certified by the Council on Recertification of Nurse Anesthetists.

B. A provider of CRNA services must be certified as a Title XVIII (Medicare) CRNA provider.

C. The following verifications must accompany the application and contract:

1. A copy of current state CRNA licensure and a current copy of national certification from the Council on Recertification of Nurse Anesthetists.

2. Verification of current Title XVIII (Medicare) Program certification. (Out-of-state CRNAs)

201.310 Group Providers of Certified Registered Nurse Anesthetist (CRNA) Services 10-13-03

Group providers of CRNA services must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program.

If a CRNA is a member of a group of providers of CRNA services, each individual CRNA and the group must both enroll to according to the following criteria:

A. Each individual CRNA within the group must enroll following the criteria established in Section 201.300.

B. The group must also be enrolled in the Title XVIII (Medicare) Program. Out-of-state providers must submit proof of current Medicare enrollment.

C. All group providers are "pay to" providers only. The service must be performed and billed by a licensed/enrolled CRNA with the group.

201.320 CRNA Providers in Arkansas and Bordering States 12-15-14

Providers of CRNA services in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as **routine services providers** if they meet all Arkansas Medicaid participation requirements outlined in Section 201.300.

Reimbursement may be available for all CRNA services covered in the Arkansas Medicaid Program. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.330 Providers of CRNA Services in States Not Bordering Arkansas 9-15-12

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.400 Arkansas Medicaid Participation Requirements for Radiation Therapy Centers 2-1-06

Providers of radiation therapy services must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. The provider must obtain and maintain a current license, certification or other proof of qualifications to operate, in conformity with the laws and rules of the state in which the provider is located.

B. The provider must be certified as a Title XVIII (Medicare) radiation therapy center in their home state.

C. The following information must be submitted with the application and contract:

1. A copy of the provider's current state license or certification.

2. A copy of the provider's Title XVIII (Medicare) certification.

201.500 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder 2-1-24

Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder must be licensed in Arkansas and be enrolled with Arkansas Medicaid.

201.510 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in Arkansas and Bordering States 2-1-24

Providers of MAT in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) may be included as routine services providers if they meet all participation requirements for enrollment in Arkansas Medicaid and requirements outlined in Section 201.500.

Reimbursement may be available for MAT covered in the Arkansas Medicaid Program when treating Opioid or Alcohol Use Disorders. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.520 Providers of Medication-Assisted Treatment (MAT) for Opioid or Alcohol Use Disorder in States Not Bordering Arkansas 2-1-24

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid Program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. **View or print the provider enrollment and contract package (Application Packet).** **View or print Provider Enrollment Unit contact information.**

B. Limited services providers remain enrolled for one (1) year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.

2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

202.000 Required Documentation

202.100 Documentation Required of All Medicaid Providers 10-1-06

A. Providers must contemporaneously create and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities of the provider in connection with its delivery of medical assistance to any Medicaid beneficiary.

B. Providers furnishing any Medicaid-covered good or service for which a prescription, admission order, physician's order, care plan or other order for service initiation, authorization or continuation is required by law, by Medicaid rule, or both, must obtain a copy of the prescription, care plan or order within five (5) business days of the date it is signed. Providers also must maintain a copy of each prescription, care plan or order in the beneficiary's medical record and follow all prescriptions, care plans, and orders as required by law, by Medicaid rule, or both.

C. The provider must make available to the Division of Medical Services, its contractors and designees and the Medicaid Fraud Control Unit all records related to any Medicaid beneficiary. When records are stored off-premise or are in active use, the provider may certify in writing that the records in question are in active use or in off-premise storage and set a date and hour within three (3) working days, at which time the records will be made available. However, the provider will not be allowed to delay for matters of convenience, including availability of personnel.

D. All records must be kept for a period of five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish medical records upon request will result in sanctions being imposed. (See Section I of this manual.)

202.200 Medical/Clinical Records Physicians are Required to Keep 10-13-03

A. Physicians are required to keep the following records for each patient:

1. History and physical examinations.
2. Chief complaint on each visit.
3. Tests and results.
4. Diagnoses.
5. Service or treatment, including prescriptions and referrals for other services.
6. Signature or initials of the physician after each visit.
7. Copies of records pertinent to services delivered by or under the supervision of the physician and billed to Medicaid.
8. Records must contain service dates of any services billed to Medicaid, including service dates for all components of global services billed.

B. The Arkansas Medicaid Program requires the attending physician's signed authorization of individualized service plans, treatment plans or plans of care developed by Medicaid non-physician providers (usually, but not exclusively, for in-home services such as home health). Physicians must maintain in the patient's medical record copies of any service

plans, treatment plans and plans of care they have so authorized. As physicians authorize subsequent revisions of the service plans, treatment plans and plans of care, copies of the revisions must be retained in the patient's medical record.

202.300 Independent Lab Services Required Documentation 9-15-13

The Arkansas Medicaid Program requires independent laboratories to maintain documentation on each patient. Documentation must include the physician's order for laboratory tests, test results and all records pertinent to billing.

Independent laboratories submitting claims to Arkansas Medicaid according to the exception noted in SSA1833(h)(5)(A)(ii)(III) shall attach modifier 90 to the procedure code. The service facility location and Arkansas Medicaid provider number will be listed in field 32 for the CMS-1500. When billing electronically, indicate the service facility location and its NPI.

202.400 CRNA Services Required Documentation 10-13-03

The Arkansas Medicaid Program requires providers of CRNA services to maintain documentation on each patient that includes all anesthesia records and all records pertinent to billing.

202.500 Radiation Therapy Center Required Documentation 10-13-03

The Arkansas Medicaid Program requires radiation therapy centers to maintain documentation on each patient that includes the physician's order for treatment, treatment record and progress sheets and all records pertinent to billing.

203.000 Physician's Role in the Medicaid Program

203.100 Introduction 1-1-18

The Arkansas Medicaid Program depends upon the participation and cooperation of Arkansas physicians for access to most categories of health care.

Most Medicaid covered services require a physician's prescription and/or certification that a service is medically necessary. Arkansas' physicians are active partners with Medicaid in the prudent use of the State's Medicaid dollars for excellent and consistent medical care. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

203.110 Ambulance Services 10-13-03

Arkansas Medicaid reimburses medically necessary ambulance transportation service for eligible Medicaid beneficiaries.

It is the responsibility of the transportation provider to maintain documentation that will verify the medical necessity of transportation provided.

203.120 Physician's Role in the Child Health Services (EPSDT) Program 8-1-07

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth up to their 21st birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with screening, diagnostic and treatment services delivered on a periodic basis.

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a preventive health care program designed for: (1) newborn health evaluations as soon after birth as possible; (2) routine, timely childhood immunizations; (3) regular screenings to detect physical or developmental health problems and (4)treatment and other measures to correct or improve any defects and chronic conditions discovered.

1. Screening

   The Arkansas Medicaid Program requires that ***all*** eligible EPSDT participants under age 21 receive regularly scheduled examinations and evaluations of their general physical and mental health, growth, development and nutritional status.

   Screenings must include, but are not limited to:

   a. Comprehensive health and developmental history.
   b. Comprehensive unclothed physical examination.
   c. Appropriate vision testing.
   d. Appropriate hearing testing.
   e. Appropriate laboratory tests.
   f. Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age.

   Screening services must be provided in accordance with reasonable standards of medical and dental practice, as soon as possible in a child's life and at intervals established by the American Academy of Pediatrics.

   An age appropriate screening may be performed when a child is being evaluated or treated for an acute or chronic condition.

   The primary care physician may provide the screening or refer the child to a qualified Medicaid provider for screening. Primary care physician referral for ESPDT screening is mandatory in the 75 counties in Arkansas. See Section I of this manual.

2. Diagnosis

   Diagnosis is the determination of the nature or cause of physical or mental disease or abnormality through the combined use of health history, physical, developmental and psychological examination, laboratory tests and X-rays.

3. Treatment

   Treatment means physician, hearing, visual services, or dental services and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.

   Physicians and other health professionals who provide Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment. If immunization is recommended at the time of screening, immunization(s) should be provided at that time .

   When a condition is diagnosed through a Child Health Services (EPSDT) screen and requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations. The PCP must request consideration for reimbursement using the EPSDT Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan Form DMS-693. **View or print form DMS-693.**

   Refer to Section I of this manual (Services Available through the Child Health Services (EPSDT) Program) for additional information.

B. Physicians who are Child Health Services (EPSDT) providers are encouraged to refer to the Child Health Services (EPSDT) provider manual for additional information.

Physicians interested in becoming a Child Health Services (EPSDT) provider should contact the central Child Health Services Office. **View or print Child Health Services Office contact information.**

203.130 Physician's Role in Adult Developmental Day Treatment (ADDT) Services 7-1-20

A. Medicaid covers Adult Developmental Day Treatment (ADDT) services when provided to eligible Medicaid beneficiaries by qualified provider facilities.

B. The Medicaid eligible beneficiary's attending physician must identify and certify with his or her original signature, the individual's medical needs that habilitation training can address. ADDT services also require a written prescription from the attending physician.

C. The services must be provided according to a written plan of care developed by the Division of Developmental Disabilities Services. The physician certifying medical necessity must sign the plan of care.

203.140 Physician's Role in Family Planning Services 1-1-23

A. Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services.

1. Medicaid clients' family planning services are in addition to their other medical benefits.
2. Family planning services do not require a PCP referral. PCPs electing not to provide some or all family planning services can use the information in this manual to counsel their Medicaid-eligible patients and help them locate family planning services.
    a. Refer to Sections 221.000 and 221.100 of the manual for family planning services benefit limitations.
    b. Refer to Sections 243.000 through 243.500 of the manual for service descriptions and coverage information.
    c. Refer to Sections 292.550 through 292.553 of the manual for family planning services billing instructions and procedure codes.

B Arkansas Medicaid covers family planning services for women in limited aid categories. Refer to Sections 221.100, and 243.000 through 243.500 for more information on coverage of family planning services for these eligibility categories.

203.150 Physician's Role in Home Health Services 12-18-15

A. Home health services are short-term and intermittent nursing care and physical therapy (when prescribed) in a client's home, under the direction of a physician.

B. Attending physicians may prescribe the following services when they are medically necessary for post-hospital care and periodic nursing care:

1. Home health aide
2. Skilled nursing
3. Physical therapy
4. Medical supplies

C. A physician's authorized and signed treatment plan must be on file with the home health agency before home health services may begin.

1. The prescribing physician must be the client's PCP unless the client is exempt from PCP program requirements.

a. The physician may add services to, or delete services from, the treatment plan submitted by the home health agency.

b. The physician may decline to prescribe home health, in accordance with his or her professional judgment.

c. Treatment plan authorization, revision and renewal must be by the physician's original signature only.

2. It is a federal requirement that the attending physician review an active treatment plan at intervals no greater than 60 days, for revision (if needed) or renewal.

3. The attending physician must maintain copies of home health treatment plans and all revisions to the treatment plans in clients' permanent files, in accordance with record-retention requirements in Section 202.000 of this manual.

D. Home health services are subject to an annual benefit limit per beneficiary. The annual benefit period is the State fiscal year (July 1 through June 30).

1. Extensions of benefits are considered for home health skilled nursing visits or home health aide visits for adults (21 years of age and older) at risk of institutionalization.

2. Benefit extensions are allowed for home health skilled nursing visits or home health aide visits for beneficiaries under age 21 in the Child Health Services (EPSDT) Program if medically necessary.

3. The home health provider is responsible for requesting a benefit extension.

203.160 Physician's Role in the Hospice Program 4-1-14

Hospice is a continuum of care, directed by professionals, designed to optimize the comfort and functionality of terminally ill patients for whom curative medicine has exhausted its possibilities. Hospice emphasizes relief from distress for the patient without actively shortening or prolonging life. Relief from distress includes palliation of physical, psychological and psychosocial symptoms of distress and a regular regime for alleviation of physical pain. All efforts are directed to the enrichment of living during the final days of life and to the provision of ongoing opportunities for the patient to be involved in life.

The physician prescribing hospice care must be the beneficiary's primary care physician (PCP) unless the beneficiary is exempt from PCP requirements.

Hospice services are defined as reasonable and medically necessary services, palliative and supportive in nature, provided to the terminally ill, for the management of the terminal illness and related conditions.

The hospice patient must be terminally ill, which is defined as having a medical prognosis with a life expectancy of six months or less. Medicaid beneficiaries are allowed personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and homemaker services. See Section 211.101 of the Hospice provider manual for policy clarification.

A. Hospices must ensure that patients receive the following physician services as needed:

1. Direct care related to the palliation and management of the patient's terminal illness and

2. Care for the hospice patient's general medical needs.

B. Hospice physicians must provide such services to the extent that the patient's attending physician does not provide them.

1. A patient's attending physician may bill Medicaid on a fee-for-service basis unless the physician is a "hospice physician", defined as providing the care:

a. As an employee of the hospice,

b. Under an arrangement with the hospice or

c. As a volunteer.

2. Hospice physicians may bill Medicaid on a fee-for-service basis, subject to the following conditions:

a. Each hospice whose physicians provide any direct patient care to the hospice's patients on a fee-for-service basis must enroll with Medicaid as a physician-billing intermediary. See Section 201.111 and Section I of this manual for participation requirements and enrollment materials.

b. Each of the hospice's physicians providing patient care for which the hospice or the physician claims Medicaid reimbursement in addition to the hospice daily rate, must authorize the hospice to bill for that care as the physician's billing intermediary. See Section 201.111 and Section I of this manual for participation requirements and enrollment materials.

c. Medicaid does not reimburse hospices for donated physician services.

203.170 Physician's Role in Hospital Services 8-1-21

A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations.

B. The care and treatment of a patient must be under the direction of a licensed physician or dentist with hospital staff affiliation. Most inpatient admissions require a PCP referral. (Refer to Section I of this manual.)

C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than four (4) days for the Medicaid Utilization Management Program.

DHS or its designated vendor also completes post-payment reviews of hospital stays of any length for medical necessity determinations. **View or print DHS or designated vendor contact information to obtain MUMP information.**

D. Hospital claims are also subject to review by the Division of Medical Services Medical Director for Clinical Affairs for the Medicaid Program.

1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to practitioners for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.

2. Practitioners and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.

3. Practitioners and hospitals may not bill as outpatient services, inpatient services previously denied for lack of medical necessity.

4. Refer to Sections I and III of this manual for Medicare deductible and coinsurance information.

203.180 Physician's Role in the Hyperalimentation Program 10-13-03

The Arkansas Medicaid Program covers medically necessary parenteral and enteral nutrition therapy in a client's place of residence when prescribed by a physician and prior-authorized by

the Utilization Review Section of the Division of Medical Services (DMS). A PCP referral is required unless the client is exempt from PCP requirements due to category of eligibility.

DMS defines "place of residence" as the client's dwelling, an apartment, relation's home or boarding house. Arkansas Medicaid does not cover enteral nutrition therapy for patients residing in a long term care facility, but does cover parenteral nutrition therapy. A period of hospitalization is required to initiate parenteral or enteral nutrition in order to train the patient in catheter care, solution preparation and infusion technique. Medicaid covers enteral nutrition therapy only when it is the sole source of nutrition. It is the responsibility of the client's attending physician to request hyperalimentation services and to provide the hyperalimentation provider with the information necessary to complete the Request for Prior Authorization and Prescription for Hyperalimentation. **View or print form DMS-2615.** This information includes the signed prescription for enteral therapy and the diagnosis and medical history confirming medical necessity. The prescription must specify the frequency and the anticipated duration of the service and whether the patient might progress from parenteral to enteral nutrition therapy. For additional information, contact the Division of Medical Services or the Medicaid provider who will furnish the hyperalimentation services.

View or print Division of Medical Services contact information.

203.190 Physician's Role in Intravenous Therapy in a Patient's Home (Home IV Therapy) 10-13-03

Home IV therapy is available to Medicaid clients who are stabilized on a course of treatment and require continuing IV therapies in the home for several days or weeks.

Medicaid guidelines for establishing and maintaining home IV therapy are:

A. The attending physician (the patient's PCP, unless the patient is exempt from PCP requirements) refers the patient to a home health provider.

B. The home health provider must assess the patient's need for home IV therapy.

C. The physician and the home health provider develop a care plan and the physician prescribes the treatment and the IV drug(s).

1. Prescriptions for IV drugs are subject to applicable Medicaid Pharmacy Program policy and Medicaid Program benefit limits.
2. The client, the client's representative or the home health provider may obtain the drug(s) under the client's prescription drug benefit.
3. The pharmacy bills Medicaid or the patient, in accordance with Medicaid Program policy.

D. The care plan must include patient training, describing the type; the amount and the frequency of self-care the patient will learn and perform.

E. The home health provider must provide and manage the IV therapy supplies.

F. The home health provider must report patient status to the prescribing physician in accordance with the physician's prescribed schedule in the care plan.

G. Nursing care attendant to the therapy will be by physician prescription and established protocol in accordance with the State Nurse Practice Act.

203.200 Physician's Role in Long Term Care Facility Placement 10-13-03

Nursing home care in a Medicaid-certified long-term care facility is available to clients for whom nursing home care is a medical necessity. Inability to live alone or prepare meals, to handle financial affairs etc., does not constitute medical necessity. Personal care may be more

appropriate for individuals with physical dependencies. Individuals needing room and board and supervision of, or assistance with, activities of daily living may be more appropriately placed in a residential care setting. A physician must recommend all applicants for Medicaid long-term-care facility placement. The physician must certify the client's need for nursing home care. Clients with diagnoses of mental retardation or mental illness undergo a separate evaluation process, the results of which the physician must also certify. Applicants diagnosed with dementia in accordance with the criteria of the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. (DSM-IV) may yet be eligible within the medical criteria for nursing home care unless they are violent or otherwise a danger to themselves or others.

203.210 Physician's Role in the Occupational, Physical, and Speech-Language Therapy Program 7-1-20

Medicaid covers occupational therapy, physical therapy, and speech-language therapy services when provided to eligible Medicaid beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program by qualified occupational, physical, or speech-language therapy providers. Occupational evaluations and occupational therapy services are payable only to a qualified occupational therapist. Speech-language therapy evaluations may be performed by the physician; however, treatment for speech-language therapy disorders must be referred to a qualified speech-language therapist. Physical therapy evaluations may be performed by the physician and physical therapy sessions may be performed by the qualified physician. Physical therapy treatment may also be referred to a qualified physical therapist.

Speech-language therapy services ONLY are covered for beneficiaries in the ARKids First-B Program benefits.

All occupational, physical, and speech-language therapy evaluations and services must be medically necessary and require a referral from the beneficiary's primary care physician (PCP) or the attending physician if the beneficiary is exempt from PCP Managed Care Program requirements. Therapy treatment services also require a prescription written by the physician who refers the patient to the therapist for specified services. For beneficiaries under age twenty-one (21), form DMS-640 must be used for the initial referral for evaluation and a separate DMS-640 is required for the prescription. **View or Print form DMS-640.** An electronic signature is accepted provided it is in compliance with Arkansas Code § 25-31-103. The physician must maintain the original Therapy and Day Habilitation Services for Medicaid Eligible Beneficiaries Prescription/Referral form–DMS-640–for each prescription in the beneficiary's medical records. The therapy provider must retain a copy of the DMS-640 in their established beneficiary medical chart/record. After the initial referral using the form DMS-640 and initial prescription utilizing a separate form DMS-640, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640.

Therapy services for individuals over age twenty-one (21) are only covered when provided through the following Medicaid Programs: Adult Developmental Day Treatment (ADDT) services, Hospital/Critical Access Hospital (CAH), Rehabilitative Hospital, Home Health, Hospice, and Physician. Refer to these Medicaid provider manuals for conditions of coverage and benefit limits.

203.220 Physician's Role in Personal Care Services 7-1-20

Personal care services are medically necessary tasks performed by a personal care aide to assist with the management of a client's physical dependencies.

The physician's role in the personal care program is to prescribe medically necessary services to assist with the client's physical dependency needs in a home or other appropriate setting. Personal care aides perform non-skilled activities such as assisting with baths, preparing meals, assisting with toileting, and cleaning the immediate living area for patients unable to partially or completely perform these tasks for themselves. It may be therapeutic for patients to perform some or all of these tasks for themselves even though it may be difficult and time consuming for

them to do so. Therefore, it is at the physician's discretion to prescribe personal care services. The Personal Care Program is not designed to provide full time services.

The physician reviews the service plan established by the provider. The physician may delete one (1) or more services from the service plan, yet, approve the remainder of the services. By signing the service plan the physician indicates his or her approval of the service plan.

If the physician has not seen the patient within the past sixty (60) days or is unable to determine whether the patient's condition warrants personal care services, he or she must request the patient make an office visit before prescribing personal care services. If the physician believes the personal care services are not medically necessary, he or she must not prescribe the services. The physician must retain a copy of the patient's service plan as well as copies of subsequent revisions to the service plan.

Medicaid beneficiaries under the age of twenty-one (21) may receive personal care in recognized locations outside the home. Public schools and Adult Developmental Day Treatment (ADDT) services provider facilities are recognized locations outside the home.

Benefit limits and other coverage restrictions may apply to Medicaid Personal Care services. Personal Care Program providers seeking authorization for service plans are expected to advise physicians regarding Medicaid clients' coverage and benefit status in the Personal Care Program.

203.230 Physician's Role in the Pharmacy Program 8-1-21

Medicaid covers prescription drugs in accordance with policies and regulations set forth in this section and pursuant to orders (prescriptions) from authorized prescribers. The Arkansas Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) that was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the DHS or designated pharmacy vendor website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

Prescribers must obtain the latest information regarding prescription drug coverage from the **DHS contracted Pharmacy Vendors website.** **View or print DHS contracted Pharmacy vendor contact information.**

203.231 Tamper Resistant Prescription Applications 2-6-17

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for ". . . amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad." This provision becomes effective on October 1, 2007. The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 1927(k)(3) of the Act provides exceptions to section 1927(k)(2) for drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other specified institutional and clinical settings. Such drugs in these settings (to the extent that they are not separately reimbursed) are exceptions to section 1927(k)(2), and, therefore, are not subject to the tamper-resistant pad requirement of section 7002(b). Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the CMS website for technical information:

https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/TRP.html

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

1. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic or compliant written prescription within 72 hours after the date on which the prescription was filled;

2. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally-specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, "electronic prescriptions" include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy by telephone by a prescriber.

203.240 Physician's Role in the Portable X-Ray Services Program 10-13-03

Medicaid covers portable X-ray services when provided to eligible Medicaid beneficiaries by qualified providers. Portable X-ray services may be covered upon the written order of the beneficiary's physician at the beneficiary's place of residence. "Place of residence" in the Portable X-Ray Services Program is defined by the Medicaid Program as the beneficiary's own dwelling, an apartment or relative's home, a boarding home, a residential care facility, a skilled nursing facility, or an intermediate care facility for the mentally retarded. Portable X-Ray Services are not covered in a hospital.

203.250 Physician's Role in the Private Duty Nursing Services Program 10-13-03

"Private Duty Nursing Services" are defined as those services that are provided by a registered nurse and/or licensed practical nurse under the direction of the beneficiary's physician. Services are provided in the beneficiary's home, a Division of Developmental Disabilities (DDS) community provider facility or a public school. (Home does not include an institution.) Private duty nursing services are not covered in a hospital, boarding home, intermediate care facility, skilled nursing facility or a residential care facility.

A. The Arkansas Medicaid Program covers private duty nursing services for Medicaid eligible ventilator-dependent beneficiaries when determined medically necessary and prescribed by the primary care physician or the attending physician if the beneficiary is exempt from PCP managed care program requirements.

B. The Arkansas Medicaid Program reimburses private duty nursing providers for high technology non-ventilator dependent beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Private duty nursing services for non-ventilator dependent beneficiaries include patients requiring the following services:

   1. Intravenous Drugs (e.g., chemotherapy, pain relief, or prolonged IV antibiotics)
   2. Respiratory – Tracheostomy or Oxygen Supplementation
   3. Total Care Support for ADLs and close patient monitoring
   4. Hyperalimentation – parenteral or enteral

   Private duty nursing services require prior authorization by the Medicaid Program. The prior authorization request must originate with the private duty nursing services provider and must be signed by the beneficiary's physician.

203.260 Physician's Role in the Prosthetics Program 10-13-03

Medicaid defines prosthetics services as durable medical equipment/oxygen, orthotic appliances, prosthetic devices, augmentative communication devices, specialized wheelchairs, wheelchair seating systems and specialized rehabilitative equipment. Prosthetic services must be medically necessary and prescribed by the beneficiary's primary care physician (PCP) unless the patient is exempt from PCP requirements. When applicable, prior authorization must be requested by the prosthetics provider.

203.270 Physician's Role in Behavioral Health Services 1-1-23

Medicaid covers behavioral health services when furnished by qualified providers to eligible Medicaid beneficiaries. A primary care physician referral is required for some behavioral health services when provided outside the physician's office.

For additional information about services that may not require PCP referral, refer to Section 172.100 of this manual.

203.271 Medication-Assisted Treatment Provider Role for Administering Opioid or Alcohol Use Disorder Services 2-1-24

SAMHSA defines Medication Assisted Treatment (MAT) as the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery. This definition and other MAT guidelines can be found at the **SAMHSA website**.

Only providers who have met the requirements of Section 201.500 may prescribe medication required for the treatment of Opioid or Alcohol Use Disorder for Arkansas Medicaid beneficiaries in conjunction with coordinating all follow-up and referrals for counseling and other services. This program applies only to prescribers of FDA-approved drugs for treatment of Opioid or Alcohol Use Disorder and will not be reimbursed for the practice of pain management.

203.290 Physician's Role in the Ventilator Program 10-13-03

A. Ventilator equipment is covered for eligible Medicaid beneficiaries in the beneficiary's place of residence when determined medically necessary and prescribed by the patient's PCP or attending physician. "Place of residence" is defined as the beneficiary's dwelling or skilled nursing facility. Ventilator equipment is not covered in a boarding home, intermediate care facility or a residential care facility.

B. Ventilator equipment is covered for an eligible beneficiary who:

1. Is medically dependent on a ventilator for life support at least 6 hours per day;
2. Has been dependent for at least 20 consecutive days as an inpatient in a hospital, skilled nursing facility or intermediate care facility;
3. But for the availability of the respiratory care services (ventilator equipment), would require respiratory care on an inpatient basis for which Medicaid would pay;
4. Has adequate social support services to be cared for at home;
5. Wishes to be cared for at home and
6. Receives services under the direction of a physician who is familiar with the technical and medical components of home ventilator support and who has medically determined that in-home care is safe and feasible for the individual.

C. Prior authorization is required. The ventilator provider completes the request for prior authorization and the physician who prescribes the equipment must sign the request form.

203.300 Physician's Role With Other State Programs 3-15-05

Medicaid-covered services may be provided by other state agencies or programs within state agencies. When these services are provided to a Medicaid beneficiary, Medicaid should be billed first for Medicaid-covered services. After Medicaid benefits have been exhausted or when Medicaid does not cover services, billings should be directed to the appropriate state program.

203.310 Physician's Role In Preventing Program Abuse 1-1-16

The Arkansas Medicaid Program must assure quality medical care for its beneficiaries and protect the integrity of the funds supporting the Program. The Division of Medical Services is committed to this goal by providing staff and resources to the prevention, detection and correction of abuse. However, these goals can be met only with the cooperation and support of the provider community. The physician is often in a position to detect certain program abuses. The Medicaid Program requests your assistance as a primary care provider to help assure quality care and the integrity of the program. (See Section I subsection 110.700 for additional information regarding the Office of Medicaid Inspector General.)

203.400 Physician's Role in Children's Advocacy Centers 7-1-24

Children's Advocacy Centers (CACs) provide a comprehensive interdisciplinary evaluation, assessment, and treatment of sexually and physically abused children under twenty-one (21) years of age. A team of professionals representing a variety of medical, social, and legal disciplines and advocates assesses the child and coordinates needed services. Sexual abuse, neglect, and physical abuse examinations are available to children under twenty-one (21) years of age through Medicaid providers who deliver and bill for the separate components of the service (physical examination). Medicaid coverage of services provided by CACs is limited to sexual abuse or neglect and physical abuse medical examinations, or both. The physician's role in CACs includes the following:

A. Serve as the medical director of the CAC;

B. Perform medical examination for sexual assault or neglect and physical abuse, or both;

C. Provide supervision of other rendering providers at the CAC who perform medical examination for neglect and physical abuse;

D. Provide supervision of Sexual Assault Nurse Examiners-Pediatric (SANE-P). Only physicians or Registered Nurses with SANE-P certification are qualified to conduct sexual assault medical examination at a CAC.

203.401 Sexual Assault Nurse Examiner Pediatric (SANE-P) Certification and Enrollment as a Provider for Arkansas Medicaid 7-1-24

Registered Nurse Certified as a Sexual Assault Nurse Examiner-Pediatric (SANE-P)

A. Registered Nurses (RNs or APRNs) must have specialized training in the evaluation and treatment of neglect and abuse of children;

B. Registered Nurses must have specialized training on the use of a colposcope;

C. Registered Nurses must be certified as Sexual Assault Nurse Examiners- Pediatric (SANE-P) by the International Association of Forensic Nurses; and

D. Enrolled as a provider with Arkansas Medicaid.

204.000 Role of Quality Improvement Organization (QIO) 10-13-03

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective efficient and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIOs are mandated to assure that Federal payment for such services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a physician's having his or her waiver of liability revoked. Once a physician has lost his or her waiver of liability, QIO reviews 100% of his or her admissions. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

205.000 Physician's "Direct Supervision" 10-13-03

The Arkansas Medicaid Program defines "direct supervision" as follows:

A. The person who is performing the service must be a paid employee of the physician who is billing the Medicaid Program. A W-4 Form must be on file in the physician's office.

B. The physician must monitor and be responsible for the quality of work performed by the employee under his/her "direct supervision." The physician must be under the same roof and be immediately available to provide assistance and direction throughout the time the service is being performed.

205.100 Physician's Supervision in the Provision of Behavioral Health Counseling Services 1-1-23

The counseling procedures covered under the Physician Program are allowed as a covered service for providers enrolled in the Primary Care Case Management (PCCM) program and when provided by the physician or by a qualified practitioner authorized by State licensure to provide them. For additional information about qualified practitioners who can provide counseling services, refer to Section II of the **Counseling Services Medicaid Provider Manual**.

When a practitioner other than a physician provides the services, the practitioner must be under supervision of a physician in the clinic that is billing for the services. For counseling services only, the term supervision means the following:

A. The person who is performing the covered service must be either of the following:

1. A paid employee of the physician who is billing the Medicaid Program. A W-4 must be on file in the physician's office; or

2. A subcontractor of the physician who is billing the Medicaid Program. A contract between the physician and the subcontractor must be on file in the physician's office;

And

3. The paid employee or subcontractor must be enrolled with Arkansas Medicaid as a performing provider in a program that allows them to provide counseling services.

B. The physician must monitor and be responsible for the quality of work performed by the employee or subcontractor under his/her supervision. The physician must be immediately available to give assistance and direction throughout the time the service is being performed.

C. Psychological testing is not covered, except as defined in the Arkansas Medicaid **Diagnostic and Evaluation manual**.

Refer to Section 292.740 of this manual for more information.

206.000 Early Intervention Reporting Requirements for Children Ages Birth to Three 10-13-03

Part C of the Individuals With Disabilities Education Act (IDEA) mandates the provision of early intervention services to infants and toddler's ages' birth to thirty-six months. Health care providers offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Early Intervention Part C Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two days of identifying them as candidates for early intervention.

A. A child must be referred if he or she is age birth to three years and meets one or more of the following criteria:

1. Developmental Delay – a delay of 25% or greater in one of the following areas of development:
   a. Physical (gross/fine motor),
   b. Cognitive,
   c. Communication,
   d. Social/emotional or
   e. Adaptive and self-help skills.
2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
   a. Down's Syndrome and chromosomal abnormalities associated with mental retardation,
   b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly and macrocephaly,
   c. Maternal Acquired Immune Deficiency Syndrome (AIDS) and
   d. Sensory impairments such as visual or hearing disorders.

B. The Division of Developmental Disabilities (DDS) within the Department of Human Services is the lead agency for Part C Early Intervention in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

C. Referrals may be made by using the form DDS/FS#0001.a, Intake/Referral/Application for Services. The referring provider must retain a copy of the referral document with the child's medical records.

210.000 PROGRAM COVERAGE

211.000 Introduction 9-15-12

A. The Arkansas Medicaid Program reimburses enrolled providers for the medical care of Medicaid beneficiaries.

B. Medicaid reimbursement is conditional upon providers' compliance with Program policy as stated in provider manuals, manual update transmittals and official Program correspondence.

C. All Medicaid benefits are based on medical necessity. Refer to the Glossary for a definition of medical necessity.

1. Service coverage will be denied and reimbursement recouped if a service is not medically necessary.
2. The finding of medical necessity may be made by the:
   a. Medical Director for Clinical Affairs for the Medicaid Program
   b. Quality Improvement Organization (QIO)

212.000 Scope 10-1-06

A. Physician services are services provided within the scope of the practice of medicine or osteopathy, as defined by State law and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy (42 Code of Federal Regulations, Section 440.50).

B. Many physician services covered by the Arkansas Medicaid Program are restricted or limited.

1. Sections 220.000 through 227.000 describe limits on the quantity of covered services beneficiaries may receive.
2. Sections 240.000 through 258.000 describe the circumstances under which certain services will be covered.

213.000 Exclusions

213.100 Inpatient Psychiatric Services 10-13-03

Psychiatric services rendered by a physician to a beneficiary in an inpatient psychiatric facility/hospital are included in the reimbursement rate of the facility/hospital. Visits that are directly related to the treatment of the patient's psychosocial condition may not be billed in addition to the facility/hospital charges.

213.110 Physician Assistant Services 10-15-09

Physician assistant services are services furnished according to Arkansas Statute 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician’s service.

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

220.000 Benefit Limits 8-1-21

Benefit limits are the limits on the *quantity* of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for “benefits exhausted.” DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not

responsible for the payment. Once the extension of benefits request has been initiated on a specific service, the provider cannot abort the process before a final decision is rendered.

Please see Section 229.000 through Section 229.120 and Section 131.000 points A and C for benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. DHS or its designated vendor reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO). **View or print contact information for DHS or its designated vendor regarding benefit limits.**

221.000 Family Planning Benefit Limits 11-1-10

A. Medicaid covers one basic family planning examination and three periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 243.000 through 243.500 of this manual for service descriptions and coverage information.

B. Prescriptions for family planning services are unlimited.

C. Extension of benefits is not available for family planning services.

D. Special billing instructions for all family planning services are in Sections 292.550 through 292.553 of this manual.

221.100 Family Planning Benefits Regarding Aid Categories 69 (FP-W) and 61 (PW-PL) 5-1-17

A. See Sections 292.551 through 292.553 for billable procedure codes.

B. Family planning services, including sterilization procedures, are also covered for women eligible in the Pregnant Woman-Poverty Level (PW-PL) category, Aid Category 61. Beneficiaries in this aid category are eligible for family planning services through the last day of the month in which the 60th postpartum day falls.

222.000 Fetal Non-Stress Test and Ultrasound Benefit Limits 2-1-22

The Arkansas Medicaid Program covers the Fetal Non-Stress Test and the Ultrasound when performed in conjunction with maternity care. Refer to **Section 292.673** of this manual for procedure codes.

A. The Ultrasound and Fetal Non-Stress Test have a benefit limit of two (2) per pregnancy.

B. Post-procedural visits are covered within the 10-day period following a fetal non-stress test.

If it is necessary to exceed the Medicaid established benefit limits, the physician must request extension of the benefit with documentation that justifies the need for additional tests and establishes medical necessity.

223.000 Injections 2-1-22

A. The Arkansas Medicaid Program applies benefit limits to some covered injections.

B. For information on coverage of injections, special billing instructions and procedure codes, refer to Sections **292.595** and **292.950** of this manual.

224.000 Inpatient Hospital Services

224.100 Inpatient Hospital Services Benefit Limit 10-13-03

A. There is an annual benefit limit of 24 medically necessary days per state fiscal year (July 1 through June 30) for Medicaid beneficiaries ages 21 and older.

B. There is no benefit limit for general and rehabilitative hospital inpatient services for clients under age 21 in the Child Health Services (EPSDT) Program.

224.200 Medicaid Utilization Management Program (MUMP) 8-1-21

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient, general and rehabilitative hospitals, in state and out-of-state. The MUMP does not apply to lengths of stay in psychiatric facilities.

Length-of-stay determinations are made by DHS or the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

224.210 MUMP Applicability 8-1-21

A. Medicaid covers up to four (4) days of inpatient service with no certification requirement, except in the case of a transfer (see part B, below). If a patient is not discharged before or during the fifth day of hospitalization, additional days are covered only if certified by DHS or its designated vendor.

B. When a patient is transferred from one hospital to another, the stay must be certified from the first day.

224.220 MUMP Exemptions 10-13-03

A. Individuals in all Medicaid eligibility categories and all age groups, except clients under age 1, are subject to this policy. Medicaid beneficiaries under age 1 at the time of admission are exempt from the MUMP policy for dates of service before their first birthday.

B. MUMP policy does not apply to inpatient stays for bone marrow, liver, heart, lung, skin and pancreas/kidney transplant procedures.

224.300 MUMP Procedures 10-13-03

MUMP procedures are detailed in the following sections of this manual:

A. Direct (non-transfer) admissions - Section 224.310

B. Transfer admissions - Section 224.320

C. Certifications of inpatient stays involving retroactive eligibility - Section 224.330

D. Inpatients with third party or Medicare coverage - Section 224.340

E. Reconsideration reviews of denied extensions - Section 224.350

224.310 Direct Admissions 8-1-21

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

Calls for extension of days may be made at any time during the inpatient stay (except in the case of a transfer from another hospital - refer to Section 224.320).

Providers initiating their request after the fourth day must accept the financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider delays calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable.

B. When a Medicaid client reaches age one (1) during an inpatient stay, the days from the admission date through the day before the patient's birthday are exempt from the Medicaid Utilization Management Program (MUMP) policy. MUMP policy becomes effective on the one-year birthday. The patient's birthday is the first day of the four (4) days not requiring MUMP certification. If the stay continues beyond the fourth day following the patient's first birthday, hospital staff must apply for MUMP certification of the additional days.

C. DHS or its designated vendor utilizes Medicaid guidelines and the medical judgment of its professional staff to determine the number of days to allow.

D. Additional extensions may be requested as needed.

E. The certification process under the MUMP is separate from prior authorization requirements. Prior authorization for medical procedures thus restricted must be obtained by the appropriate providers. Hospital stays for restricted procedures may be disallowed if required prior authorizations are not obtained.

F. Out-of-state claims (claims from providers in non-bordering states) are subject to the determination for medical necessity for out-of-state treatment. In addition, the claim and records will be reviewed retrospectively for lengths of stay beyond the four (4) days allowed.

G. Claims submitted without an approved extension request will result in automatic denials of any days billed beyond the fourth day. No exceptions will be granted except for claims reflecting third party liability.

224.320 Transfer Admissions 8-1-21

If a patient is transferred from one hospital to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to certify the inpatient stay. **View or print contact information to obtain the DHS or designated vendor step-by-step process to request certification**.

224.330 Retroactive Eligibility 8-1-21

A. If eligibility is determined while the patient is still an inpatient, the hospital may request post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer) and a concurrent certification of additional days, if needed.

B. If eligibility is determined after discharge the hospital may contact DHS or its designated vendor for post-certification of inpatient days beyond the first four (4) (or all days if the admission was by transfer). If certification sought is for a stay longer than thirty (30) days, the provider must submit the entire medical record for review.

224.340 Third Party and Medicare Primary Claims 8-1-21

A. If a provider has not requested Medicaid Utilization Management Program (MUMP) certification of inpatient days because there is apparent coverage by insurance or Medicare Part A, but the other payer has denied the claim for non-covered service, lost eligibility, benefits exhausted, etc., post-certification required by the MUMP may be obtained. **View or print contact information to obtain the DHS or designated vendor step-by-step process**.

B. If a third-party insurer pays the provider for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

224.350 Requests for Reconsideration 8-1-21

Reconsideration reviews of denied extensions may be requested by sending the medical record to DHS or its designated vendor. The hospital will be advised of the reconsideration decision by the next working day.

View or print contact information to obtain the DHS or designated vendor step-by-step process for reconsideration requests.

224.400 Post Payment Review 10-13-03

A post payment review of a 30% random sample is conducted on all admissions, including inpatient stays *of four days or less*, to ensure that medical necessity for the services is substantiated.

225.000 Outpatient Hospital Benefit Limit 7-1-22

Medicaid-eligible clients twenty-one (21) years or older are limited to a total of twelve (12) outpatient hospital visits a year. This benefit limit includes outpatient hospital services provided in an acute care, general, or a rehabilitative hospital. This yearly limit is based on the State Fiscal Year (SFY/July 1 through June 30).

A. Outpatient hospital services include the following:

1. Non-emergency professional visits in the outpatient hospital and related physician, advanced practice registered nurse (APRN), and physician assistant services.
2. Outpatient hospital therapy and treatment services and related physician, APRN, and physician assistant services.

B. Extension of benefits will be considered for clients based on medical necessity.

C. The Arkansas Medicaid Program automatically extends the outpatient hospital visit benefit for certain primary diagnoses. Those diagnoses are:

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.**)
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

D. When a Medicaid eligible client's primary diagnosis is one (1) of those listed above and the Medicaid eligible client has exhausted the Medicaid established benefit limit for outpatient hospital services and related physician, APRN, and physician assistant services, the provider does not have to file for an extension of the benefit limit.

E. All outpatient hospital services for clients under age twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program are not benefit limited.

F. Emergency and surgical physician services provided in an outpatient hospital setting are not benefit limited.

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.

225.200 Computed Tomographic Colonography (CT Colonography) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center 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 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 an obstruction neoplasm, spasm, 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 signs or 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. biopsy) or for treatment (e.g. polypectomy), virtual colonography is not reimbursable when used as an alternative to an instrument/fiberoptic colonoscopy, even though 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.
   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 the 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.
2. The results of an instrument/fiberoptic colonoscopy performed before the virtual colonoscopy (CT colonography) which was incomplete must be retained in the patient's record.
3. The patient's medical record must include the following and be available upon request:
   a. The order/prescription from the referring physician
   b. Description of polyps/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. 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); and

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)
incompletely characterized lesions
e.g., hypodense renal or liver lesion

v. E4 - Clinically important findings (work-up needed)
e.g., solid renal or liver mass, aortic aneurysm, adenopathy

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

E. See Section 292.603 for billing protocol.

226.000 Physician Services Benefit Limit 7-1-22

Physician Program

A. For clients twenty-one (21) years of age or older, services provided in a physician's office, advanced practice registered nurse's (APRN) office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

Clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) Program are not subject to this benefit limit.

The following services are counted toward the service benefit limits:

1. Services of physicians in the office, client's home, or nursing facility.
2. Medical services provided by a dentist.
3. Medical services furnished by an optometrist.

4. Certified nurse-midwife services.
5. APRN services in the office, client's home, or nursing facility.
6. Rural health clinic (RHC) encounters.
7. Federally qualified health center (FQHC) encounters.

B. Extensions of this benefit are considered when documentation verifies medical necessity. Refer to Sections 229.100 through 229.120 of the manual for procedures on obtaining extension of benefits for Primary Care Provider (PCP) services.

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 or AIDS (**View ICD Codes.**).
3. Renal failure (**View ICD Codes.**).
4. Pregnancy* (**View ICD Codes.**).
5. Opioid Use Disorder when treated with MAT (**View ICD OUD Codes.**)

When a Medicaid client's primary diagnosis is one (1) of those listed above and the client has exhausted the Medicaid established benefit for physician, APRN, and physician assistant services, outpatient hospital services, or laboratory and X-ray services, a request for extension of benefits is not required.

*OB ultrasounds and fetal non-stress tests are not exempt from Extension of Benefits. See Section 292.673 for additional coverage information.

226.100 Consultations 10-13-03

A. A consultation is an evaluation and management service as defined by Physician's Common Procedural Terminology (CPT).

B. Physician consultations are limited to two (2) per client per State Fiscal Year (July 1 through June 30).

1. Consulting physicians may bill Medicaid for only one consultation per Medicaid-eligible patient, for service dates within a State Fiscal Year (July 1 through June 30).
2. Medicaid does not cover follow-up consultations. A consulting physician assuming care of a patient is providing a primary evaluation and management service and bills Medicaid accordingly, within CPT standards.

C. Clients under age 21 in the Child Health Services (EPSDT) Program are eligible for extension of the physician consultation benefit if the extension is medically necessary.

226.200 Telemedicine 8-1-18

See Section I for Telemedicine policy and Section III for Telemedicine billing protocol.

226.210 Reserved 8-1-18

226.220 Reserved 8-1-18

227.000 Physical and Speech-Language Therapy Services 1-1-21

A. Arkansas Medicaid applies physical and speech-language therapy benefits for beneficiaries of all ages. For range of benefits, see the following procedure codes: **View or print the procedure codes for therapy services**.

1. Speech-language therapy (individual and group sessions) are payable only to a qualified speech-language therapist.

2. For beneficiaries under age 21, Arkansas Medicaid will reimburse the physician for make-up therapy sessions in the event a physical therapy session is canceled or missed. Make-up therapy sessions are covered when medically necessary and prescribed by the beneficiary's primary care physician (PCP) or attending physician, if the beneficiary is exempt from PCP Managed Care Program requirements. A new prescription, signed by the PCP, is required for each make-up therapy session.

B. Extended therapy services may be provided for physical and speech-language therapy services based on medical necessity for Medicaid beneficiaries under age 21. Refer to Sections 229.200 through 229.240 of this manual for procedures for obtaining extended services.

C. Benefit Extensions may be provided for physical therapy, based on medical necessity, for Medicaid beneficiaries 21 years of age and over when provided within a covered program in accordance with Sections 229.100 through 229.140 of this manual.

227.100 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 7-1-15

Arkansas Medicaid employed retrospective review of occupational, physical and speech therapy services for beneficiaries under age 21. The purpose of retrospective review is promotion of effective, efficient and economical delivery of health care services.

The Quality Improvement Organization (QIO) under contract to the Arkansas Medicaid Program performs retrospective reviews by reviewing medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements. **View or print AFMC contact information.**

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines are included for information to physicians prescribing and/or providing therapy services. The guidelines may be found in Sections 227.200 through 227.320

227.200 Occupational and Physical Therapy Guidelines for Retrospective Review 7-1-20

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist; and

3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluations and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation;
2. Child's name and date of birth;
3. Diagnosis specific to therapy;
4. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

   NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

   7 months - [(40 weeks) - 28 weeks) / 4 weeks]

   7 months - [(12) / 4 weeks]

   7 months - [3]

   4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores, or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services;
6. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone, or a narrative description of the child's functional mobility skills (strengths and weaknesses);
8. An interpretation of the results of the evaluation including recommendations for therapy/minutes per week;
9. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized, and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components, and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one (1) subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by

the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.

5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason a standardized test could not be used must be included in the evaluation.
6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability/validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by Arkansas Medicaid for retrospective reviews.
7. Range of Motion: A limitation of greater than ten (10) degrees or documentation of how a deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as the amount of assistance required to perform transfer, i.e., maximum, moderate, or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age twenty-one (21)) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age two (2)) in the Early Intervention Day Treatment (EIDT) program must be evaluated every six (6) months.
13. Children (age three (3) to twenty-one (21)) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three (3) years; however, an annual update of progress is required.

D. Frequency, Intensity, and Duration of Physical or Occupational Therapy Services

The frequency, intensity, and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.
3. Duration of Services: Therapy services should be provided if reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring, or establishment of a home program, should be implemented.

E. Progress Notes

1. Child's name;
2. Date of service;

3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of entry with a full signature and credentials; and
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

227.210 Accepted Tests for Occupational Therapy 3-15-12

To view a current list of accepted tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services manual.

227.220 Accepted Tests for Physical Therapy 3-15-12

To view a current list of accepted tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

227.300 Speech-Language Therapy Guidelines for Retrospective Review 7-1-20

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is insufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist; and
3. There must be a reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension or use of spoken, written or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) or the perception/processing of language. Language disorders may involve one (1), all, or a combination of the above components.
2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice, or fluency. Speech Production disorders may involve one (1), all, or a combination of these components of the speech production system.

   An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e., phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e., verbal or oral apraxia, dysarthria.
3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based) involved with the entire

act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

   Mild: Scores between 84-78; -1.0 standard deviation

   Moderate: Scores between 77-71; -1.5 standard deviations

   Severe: Scores between 70-64; -2.0 standard deviations

   Profound: Scores of sixty-three (63) or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

   a. Date of evaluation;

   b. Child's name and date of birth;

   c. Diagnosis specific to therapy;

   d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

      NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

      7 months - [(40 weeks) - 28 weeks) / 4 weeks]

      7 months - [(12) / 4 weeks]

      7 months - [3]

      4 months

   e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients, or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

   f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

   g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures;

   h. Formal or informal assessment of hearing, articulation, voice, and fluency skills.

   i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

   j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

   k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

   a. Date of evaluation;

   b. Child's name and date of birth;

   c. Diagnosis specific to therapy;

   d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

      NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

      7 months - [(40 weeks) - 28 weeks) / 4 weeks]

      7 months - [(12) / 4 weeks]

      7 months - [3]

      4 months

   e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

   f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

   g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

   h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

   i. Formal or informal assessment of hearing, voice, and fluency skills;

   j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

   k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

   l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

   a. A medical evaluation to determine the presence or absence of a physical etiology is a prerequisite for evaluation of voice disorder;

   b. Date of evaluation;

c. Child's name and date of birth;

d. Diagnosis specific to therapy;

e. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

j. Formal or informal assessment of hearing, articulation, and fluency skills;

k. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

l. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation;

b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week

gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients, or indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures;

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen, or TTFC;

i. Formal or informal assessment of hearing, articulation, and voice skills;

j. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

k. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 227.300, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation;

b. Child's name and date of birth;

c. Diagnosis specific to therapy;

d. Background information including pertinent medical history; and, if the child is twelve (12) months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before forty (40) weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of four (4) months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients, or

indexes, if applicable. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.);

f. If swallowing problems or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made;

g. If applicable, test results should be adjusted for prematurity (less than thirty-seven (37) weeks gestation) if the child is twelve (12) months of age or younger, and this should be noted in the evaluation;

h. Formal or informal assessment of hearing, language, articulation, voice, and fluency skills;

i. An interpretation of the results of the evaluation, including recommendations for frequency and intensity of treatment;

j. A description of functional strengths and limitations, a suggested treatment plan, and potential goals to address each identified problem; and

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two (2) language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one (1) being a norm-referenced, standardized test with good reliability and validity. (Use of two (2) one-word vocabulary tests alone will not be accepted.)

   a. For children age birth to three (3): criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

   b. For children age three (3) to twenty-one (21): criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 227.300, part D, paragraph 8.)

   c. Age birth to three (3): Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two (2) measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

   d. Age three (3) to twenty-one (21): Eligibility for language therapy will be based upon two (2) composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION OR PHONOLOGY: Two (2) tests or procedures must be administered, with at least one (1) being from a norm-referenced, standardized test with good reliability and validity.

   Eligibility for articulation or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

3. APRAXIA: Two (2) tests or procedures must be administered, with at least one (1) being a norm-referenced, standardized test with good reliability and validity.

   Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two (2) tests. When -1.5 SD or greater is not indicated by both tests, corroborating data from a criterion-referenced test or accepted

procedures can be used to support the medical necessity of services. (For a list of accepted tests, refer to Section 214.410 of the Occupational, Physical, and Speech-Language Therapy Services Manual.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

   Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one (1) norm-referenced, standardized test with good reliability and validity, and at least one (1) supplemental tool to address effective components.

   Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

   Eligibility for oral-motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by a videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components, and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth, functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

   a. The reason standardized testing is inappropriate for this child;

   b. The communication impairment, including specific skills and deficits; and

   c. The medical necessity of therapy.

   Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age twenty-one (21)) receiving services outside of the schools must be evaluated annually.

10. Children (birth to twenty-four (24) months) in the Early Intervention Day Treatment (EIDT) Program must be evaluated every six (6) months.

11. Children (age three (3) to twenty-one (21)) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three (3) years; however, an annual update of progress is required.

12. Children (age three (3) to twenty-one (21)) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name;

2. Date of service;

3. Time in and time out of each therapy session;
4. Objectives addressed (should coincide with the plan of care);
5. A description of specific therapy services provided daily, and the activities rendered during each therapy session, along with a form of measurement;
6. Progress notes must be legible;
7. Therapists must sign each date of the entry with a full signature and credentials; and
8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

227.310 Accepted Tests for Speech-Language Therapy 3-15-12

To view a current list of accepted tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services manual.

227.400 Recoupment Process 11-1-08

The Division of Medical Services (DMS), Utilization Review (UR) is required to initiate the recoupment process for all claims that the Quality Improvement Organization (QIO) has denied for not meeting the medical necessity requirement. Based on QIO findings during respective reviews, UR will initiate recoupment as appropriate.

Medicaid will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

228.000 Reserved 4-1-14

229.000 Procedures for Obtaining Extension of Benefits

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).

229.130 Administrative Reconsideration of Extensions of Benefits Denial 8-1-21

A. A request for administrative reconsideration of an extension of benefits denial must be in writing and submitted to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation pursuant to Section 229.120.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the manual. A request received within thirty-five (35) calendar days of a denial will be deemed timely. A request received later than thirty-five (35) calendar days gives rise to a rebuttable presumption that it is not timely.

229.140 Appealing an Adverse Action 2-1-06

Please see Section 190.000 *et al*. for information regarding administrative appeals.

229.200 Procedures for Obtaining Extended Therapy Services for Beneficiaries Under 21 Years

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.

229.220 Documentation Requirements 1-1-09

A. To request extended therapy services, all applicable documentation that supports the medical necessity of extended benefits is required.

B. Documentation requirements are as follows. Clinical records must:

1. Be legible and include documentation supporting the specific request
2. Be signed by the performing provider
3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider

229.230 Extended Therapy Services Review Process 8-1-21

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

229.240 Administrative Reconsideration 8-1-21

A request for administrative reconsideration of the denial of services must be in writing and sent to DHS or its designated vendor within thirty (30) calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of the Arkansas Medicaid manual. A request received by DHS or its designated vendor within thirty-five (35) calendar days of a denial will be deemed timely.

230.000 Medication-Assisted Treatment for Opioid Use Disorder 9-1-20

A. MAT is covered for eligible Medicaid beneficiaries who have an Opioid Use Disorder when diagnosis and clinical impression is determined in the terminology of ICD.

B. Providers are required to follow SAMHSA guidelines for the full provision of MAT.

C. Providers are encouraged to use telemedicine services when in-person treatment is not readily accessible.

D. In accordance with SAMHSA guidelines, MAT requires at a minimum:

a. **Initial evaluation and diagnosis of Opioid Use Disorder, including:**

i. Drug screening tests to accompany proper medication prescribing for MAT. Buprenorphine mono-therapy is typically reserved only for pregnant women and those with a documented anaphylactic reaction to other MAT medications like Buprenorphine/Naloxone combinations.

ii. Lab screening tests for communicable diseases, as appropriate based on the patient's history.

iii. Use of all necessary consent forms for treatment and HIPAA compliant communication.

iv. Execution of a Treatment Agreement or Contract such as SAMHSA's sample treatment agreement found under Tip 63 on the SAMHSA website: **https://www.samhsa.gov/search_results?k=Opioid+Use+Disorder**. Providers may develop their own agreement or contract as long as it contains all elements listed within SAMHSA's sample agreement.

v. Development of a Person-Centered Treatment Plan.

vi. Referral for independent clinical counseling or documented plan for integrated follow-up visit including counseling.

vii. Identification of a MAT team member to function as the case manager to offer support services.

b. **Continuing Treatment (first year):**

i. Regular outreach to the patient to determine need for assistance in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.

ii. At least one (1) follow-up MAT office visit per month for medication and treatment management.

iii. Drug testing in conjunction with each monthly visit.

iv. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit including counseling per month.

c. **Maintenance Treatment (subsequent years)**

i. Regular outreach to the patient to determine need for assistance in accessing resources, providing information on available programs and supports in the community, and referrals as needed to other practitioners.

ii. At least one (1) follow-up MAT office visit quarterly for medication and treatment management.

iii. Drug testing in conjunction with each quarterly visit.

iv. At least one (1) independent clinical counseling visit or documented plan for integrated follow-up visit including counseling at an amount and duration medically necessary for continued recovery.

230.100 Compliance with SAMHSA Guidelines 9-1-20

Arkansas Medicaid or its designated authority will periodically review claims for MAT to ensure provider compliance with minimum requirements set forth in this manual and with the SAMHSA guidelines that are current as of the date of services. Failure to comply with minimum requirements for the program may result in recoupment or other sanctions outlined in Section I of the Arkansas Medicaid Provider Manual.

MAT providers are expected to adhere to the SAMHSA guidelines when providing MAT. We understand MAT providers may not be able to control all elements of treatment when referred and provided by other practitioners. However, to ensure the effectiveness of the program, the MAT provider is responsible for case management and adjusting the treatment plan for the beneficiary's maximum progress. Documentation regarding how the MAT provider is monitoring and addressing non-compliance will be reviewed. For example, when a client routinely misses office visits or referred counseling appointments or is otherwise not following the MAT program, the client should be appropriately tapered off medication if necessary. In the patient/prescriber agreement, the provider would set out those expectations in accordance with SAMHSA guidelines. If counseling or other components of treatment are being referred, those providers' records are also subject to post payment review and recoupment for services not documented as compliant with SAMHSA guidelines.

240.000 Coverage Restrictions

241.000 Fluoride Varnish Treatment 2-1-22

Arkansas Medicaid will expand coverage for fluoride varnish application, ADA code, to physicians and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The online training course can be accessed at **http://ar.train.org**. The provider will need to maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

242.000 Dermatology 2-1-22

The Arkansas Medicaid Program covers CPT procedure code Actinotherapy (ultraviolet light). The physician must submit documentation with claim to establish medical necessity.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

243.000 Family Planning Coverage Information 11-1-10

A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, clinics and hospitals for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Abortion is not a family planning service in the Arkansas Medicaid Program.

B. Physicians desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 243.300 through 243.500 to Medicaid beneficiaries of childbearing age.

C. Physicians preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include:

1. Arkansas Department of Health local health units
2. Obstetricians and gynecologists
3. Nurse practitioners
4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics

D. Complete billing instructions for family planning services are in Sections 292.550 through 292.553 of this manual.

243.100 Reserved 5-1-17

243.200 Family Planning Services for Women in Aid Category 61, PW 1-1-23

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services. Clients *in aid category 61* Pregnant Women (PW) *are eligible for family planning services through the last day of the month in which the 60th day postpartum falls.*

243.300 Basic Family Planning Visit 10-1-06

Medicaid covers one basic family planning visit per beneficiary per Arkansas state fiscal year (July 1 through June 30). This basic visit comprises the following:

A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight and blood pressure

B. Counseling and education regarding

1. Breast self-exam
2. The full range of contraceptive methods available
3. HIV/STD prevention

C. Prescription for any contraceptives selected by the beneficiary

D. Laboratory services, including, as necessary

1. Pregnancy test
2. Hemoglobin and Hematocrit
3. Sickle cell screening
4. Urinalysis testing for albumin and glucose
5. Papanicolaou smear for cervical cancer
6. Testing for sexually transmitted diseases

243.400 Periodic Family Planning Visit 10-1-06

Medicaid covers three periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visits is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

243.500 Contraception 12-1-21

A. Prescription and Non-Prescription Contraceptives

1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
2. Medicaid covers non-prescription contraceptives as a family planning benefit when a physician writes a prescription for them.

B Contraceptive Implant Systems

1. Medicaid covers the contraceptive implant systems, including implants and supplies.
2. Medicaid covers insertion, removal and removal with reinsertion.

C. Intrauterine Device (IUD)

1. Medicaid pays for IUDs as a family planning benefit.
2. Alternatively, Medicaid reimburses physicians that supply the IUD at the time of insertion.
3. Medicaid pays physicians for IUD insertion and removal.

D. Medroxyprogesterone Acetate

Medicaid covers medroxyprogesterone acetate injections for birth control.

E. Sterilization

1. All adult (21 or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
2. Medicaid covers Occlusion by Placement of Permanent Implants. Coverage includes the procedure, the implant device and follow-up procedures as specified in Section 292.553.
3. Refer to Section 251.290 of this manual for Medicaid policy regarding sterilization.
4. Refer to Sections 292.550 through 292.553 of this manual for family planning procedure codes and billing instructions for family planning services.

244.000 Covered Drugs and Immunizations 2-15-15

The Arkansas Medicaid Program provides coverage of drugs for treatment purposes and for immunizations against many diseases. Most of these are administered by injection. Appropriate procedure codes may be found in the CPT and HCPCS books and in this manual. The following types of drugs are covered.

A. Chemotherapy and immunosuppressive drugs. (See Section 292.950.) No take-home drugs are covered.

B. Desensitization (allergy) injections for beneficiaries in the Child Health Services (EPSDT) program. (See Section 292.420 of this manual for billing instructions.)

C. Immunizations, childhood and those covered for adults. (See Section 292.950 of this manual for special billing instructions.)

D. Other injections that are covered for specific diagnoses and/or conditions. See Section 292.950. No take-home drugs are covered.

244.001 Reserved 4-1-14

244.002 Reserved 4-1-14

244.003 Fluocinolone Acetonide Intravitreal Implant (Retisert) 10-1-15

Medicaid covers Retisert implantation for ages and indications approved by the FDA under the following conditions:

NOTE: Supply of the Fluocinolone Acetonide Intravitreal Implant (Retisert) is only payable to the hospital provider.

A. There must be documentation by eye exam of an ICD diagnosis of chronic non-infectious uveitis of the posterior segment of the eye. (**View ICD Codes.**)

B. An evaluation by an ophthalmologist documenting failure of all other treatments and complications that will lead to blindness must be clearly stated.

C. Which eye will be treated with that administration should be clearly documented along with current visual acuity.

D. All requests will be reviewed on a case-by-case basis.

E. The physician must obtain a Prior Approval letter from the Division of Medical Services Medical Director for Clinical Affairs. The Prior Approval letter must be provided to the hospital provider for billing for the provision of the implant. See Section 244.100 for instruction on obtaining Prior Approval letters.

NOTE: The procedure code for the implant is NOT payable to the physician. The physician may bill for the procedure to do the implantation.

F. Physician is to provide the hospital with a copy of the prior approval letter at the time of the implantation procedure

244.100 Special Pharmacy, Therapeutic Agents and Treatments 2-15-15

Providers must obtain prior approval, in accordance with the following procedures, for special pharmacy, therapeutic agents and treatments.

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

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

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

1. The provider must submit a history and physical examination with the treatment protocol before beginning the treatment.

2. The provider will be notified by mail of the DMS Medical Director of Clinical Affairs' decision. No prior authorization number is assigned if the request is approved, but a

prior approval letter is issued and must be attached to each claim. Any changes in treatment require resubmission and a new approval letter.

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

Refer to Sections 292.595 and 292.950 for pharmacy and therapeutic agents for special billing procedures.

See Sections 258.000 and 292.860 for coverage and billing procedures for hyperbaric oxygen therapy.

244.200 Radiopharmaceutical Therapy 9-15-12

Medicaid covers radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion.

Before beginning therapy the provider must submit the following documentation.

A. Patient history and physical report is required.

B. Drugs and therapeutic procedures previously administered must be included along with documentation that conventional therapy has failed.

C. This information must be sent to the attention of the Medical Director for Clinical Affairs of the Division of Medical Services.

The provider will be notified by mail of the Medical Director for Clinical Affairs' decision. If approval is received, the provider must file the claim for service with a copy of the approval letter and a copy of the invoices for the monoclonal antibody.

Refer to Section 292.595 for special billing procedures.

245.000 Laboratory and X-Ray Services Referral Requirements 10-1-15

A. A physician, referring a Medicaid client for laboratory, radiology or machine testing services, must specify a diagnosis (ICD coding) for each test ordered *and include in the order*, pertinent supplemental diagnoses supporting the need for the test(s).

1. Reference diagnostic facilities and hospital labs and outpatient departments performing reference diagnostics, rely on the referring physicians to establish medical necessity.
2. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.
3. Physicians must follow 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. ICD diagnosis codes (**View ICD Codes.**) are unacceptable as primary or secondary diagnoses on claims submitted to Medicaid, because they do not establish medical necessity.

B. The referring physician's individual provider identification number must also accompany the order.

1. If the client's PCP referred the client to the physician ordering the tests, the ordering physician must include with the order the PCP's individual provider identification number, in addition to his or her own individual provider identification number.
2. The reference facility retains the ordering physician's provider information with the client's medical record for the medical necessity audit trail.
3. The reference facility enters the PCP's provider identification number on its claim(s) to certify PCP referral.
4. If the Medicaid client is exempt from PCP Program requirements, the reference facility submits the individual provider identification number of the ordering physician on its Medicaid claim.

246.000 Non-Core Rural Health Clinic (RHC) Services 10-13-03

A. RHC non-core services provided to patients of the RHC by physicians contracted or employed by the RHC are covered under certain conditions. See Section 201.111 of this manual and the Rural Health Clinic (RHC) provider manual for the participation requirements.

B. RHC non-core services include:

1. Emergency and non-emergency outpatient hospital visits;
2. Inpatient hospital visits;
3. Surgeries performed in the inpatient and outpatient hospital or in an ambulatory surgical center;
4. Technical components of radiology procedures and
5. Technical components of electrocardiograms and echocardiography.

C. Inpatient and outpatient hospital visits, home and nursing facility visits or other off-site visits are RHC encounters if the physician's agreement with the RHC requires he or she provide the services and seek compensation from the RHC.

247.000 Obstetrical Services 3-15-05

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiaries. These services include prenatal services, delivery and postpartum care. Please refer to Sections 292.670 through 292.676 of this manual for special billing instructions for pregnancy-related services.

247.100 Pregnant Women in the PW Aid Category 1-1-23

Women in Aid Category 61 (PW) receive the full range of Medicaid benefits. Aid Category 61 also includes benefits to unborn children of alien pregnant women who meet the eligibility requirements. The benefits for this eligibility category are:

A. Prenatal services

B. Delivery

C. Postpartum services for 60 days (plus the days remaining in the month in which the 60-day period ends)

D. Services for conditions that may complicate the pregnancy

System eligibility verification will specify "PW unborn ch-no ster cov/FP."

Aid Category 61 PW Unborn Child does not include family planning benefits.

247.200 Risk Management Services for Pregnancy 2-1-22

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in the service descriptions below. If a physician does not choose to provide risk management services but believes the patient would benefit from them, he or she may refer the patient to a clinic that offers risk management services for pregnancy.

Each of the covered risk management services described in parts A through E has a limited number of units of service that may be furnished. Coverage of these risk management services is limited to a maximum of 32 cumulative units.

A. Risk Assessment

A medical, nutritional and psychosocial assessment is completed by the physician or registered nurse to designate patients as high or low risk.

1. Medical assessment using the Hollister Maternal/Newborn Record System or equivalent form to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
2. Nutritional assessment to include:
   a. Medical history
   b. Menstrual history
   c. Pregnancy history
3. Psychosocial assessment to include criteria for an identification of psychosocial problems that may adversely affect the patient's health status

Maximum: 2 units per pregnancy

B. Case Management Services

Services by a physician, licensed social worker or registered nurse that will assist pregnant women eligible under Medicaid gain access to needed medical, social, educational and other services (examples: locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver the newborn, follow-up to verify the patient kept an appointment, rescheduling appointments). Services may be provided for low-risk or high-risk cases as determined by the risk assessment.

Maximum: 1 unit per month. A minimum of two contacts per month must be provided. A case management contact may be with the patient, other professionals, family and/or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (Physician, Public Health Nurse, Nutritionist, or Health Educator) to include:

1. Pregnancy
2. Labor and delivery
3. Reproductive health
4. Postpartum care
5. Nutrition in pregnancy

Maximum: 6 classes (units) per pregnancy

D. Nutrition Consultation – Individual

Services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration, to include at least one of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan
2. Nutritional care plan follow-up and reassessment as indicated

Maximum: 9 units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker to include at least one of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: 6 units per pregnancy

F. Early Discharge Home Visit

If a physician chooses to discharge a low-risk mother and newborn from the hospital early (less than 24 hours), the physician or registered nurse employee may provide a home visit to the mother and baby within 72 hours of the hospital discharge or the physician may request an early discharge home visit from any clinic which provides perinatal services. Visits will be done by physician order (including hospital discharge order).

A home visit may be ordered for the mother and/or infant discharged later than 24 hours if there is a specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 292.676** of this manual.

248.000 Psychotherapy and Psychological Testing 10-13-03

The Arkansas Medicaid Program's policy regarding psychology services and psychotherapy is:

A. Psychotherapy is reimbursable to a physician when provided by a physician or under the physician's "direct supervision." Refer to Section 205.100 and Section 292.740 of this manual.

B. Psychological testing is not covered, except in a certified community mental health center or in the psychology program for beneficiaries in the Child Health Services (EPSDT) Program when services are provided by a psychologist who is enrolled in the Medicaid Program.

249.000 Inpatient Evaluation and Management Services 10-13-03

A. Medicaid covers inpatient physician evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is discharge day management. Medicaid does not remit the hospital's per diem for the day of discharge unless it is also the admission day. Medicaid reimburses physicians for medically necessary discharge day management unless physician evaluation and management services for that day are included in another service, such as surgery,

delivery, or routine newborn care; or unless the physician does not customarily bill private-pay patients for discharge day management.

B. Arkansas Medicaid covers one evaluation and management visit per Medicaid-covered inpatient day per attending physician.

1. Each physician attending the patient must be of a different specialty, or
2. Attending physicians of the same specialty must be seeing the patient for different medical conditions if they both bill Medicaid.

Refer to Section 251.000 of this manual for policy regarding post-surgery physician visits.

Refer to Section 224.100 for inpatient hospital benefit limits.

249.100 Professional Components of Diagnostic and Therapeutic Procedures 10-13-03

Medicaid reimbursement to hospitals for inpatient services includes the non-physician components (technical components) of machine tests, laboratory and radiology procedures provided to inpatients.

Reimbursement to physicians and independent laboratories for laboratory and radiology services for inpatients is solely for professional component of machine tests, radiology and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed in the course of diagnosing and treating a hospital inpatient. Hospitals must furnish or purchase those ancillary services.

See Section 292.730 for definitions of “complete procedure,” “technical component” and “professional component.”

250.000 Outpatient Hospital Physician Services 10-13-03

Coverage restrictions in the outpatient hospital setting apply to all physician services. Outpatient hospital services include the non-physician services related to machine tests, laboratory and radiology procedures (including radiation therapy) performed on behalf of patients in an outpatient hospital setting.

Medicaid covers only the professional component of laboratory and radiology services performed on behalf of patients in the outpatient hospital by physicians. These services include machine tests, radiology and anatomical laboratory services. This applies to all physician services, regardless of whether the physician is hospital based or not. The hospital may not bill for hospital based physician services on the outpatient hospital claim form CMS-1450 (formerly UB-92). **View a sample CMS-1450.**

For the purpose of coverage and reimbursement determination, outpatient hospital physician services are divided into four types of services in Sections 250.100 through 250.400.

250.100 Emergency Services 10-13-03

Physicians may bill a hospital outpatient visit as an emergency when the beneficiary’s medical condition constitutes an emergency medical condition. See the Glossary of this manual for the definition of emergency services

250.200 Physician Assessment in the Hospital Emergency Department 2-1-22

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid has a physician assessment fee. (See **Section 292.682** for procedure code and billing instructions.) The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a primary care physician. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

250.300 Non-Emergency Services 10-13-03

Coverage of non-emergency physician services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology and anatomical laboratory procedures.

250.400 Therapy and Treatment 10-13-03

A. Special Coverage Requirements - The professional services related to the following are covered as outpatient hospital physician treatment/therapy services:

1. Dialysis
2. Radiation therapy
3. Respiratory therapy
4. Burn therapy

B. Professional services related to the following outpatient hospital physician treatment/therapy services may not be billed:

1. Physical therapy
2. Factor VIII and factor IX products
3. Chemotherapy
4. Covered injections
5. Occupational therapy
6. Speech therapy

C. Any treatment/therapy services not listed will be covered under either emergency or non-emergency services.

250.500 Observation Status 10-1-06

When billing for services to a patient in "observation status," physicians must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Physicians must also follow the guidelines and definitions in **Physician's Current Procedural Terminology (CPT),** under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

A. Arkansas Medicaid uses the following criteria in determining inpatient and outpatient status:

1. If a patient is expected to remain in the hospital for less than 24 consecutive hours and this expectation is realized, the hospital and the physician should consider the patient an outpatient; i.e., the patient is an outpatient unless the physician has admitted them as an inpatient.
2. If the physician or hospital expects the patient to remain in the hospital for 24 hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, even though the physician has not yet formally admitted the patient.

3. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for 24 consecutive hours, even if the physician or hospital had no prior expectation of a stay of that or greater duration.

B. Medical Necessity Requirements

1. Physician inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the physician admitted the patient, or whether Medicaid deemed the patient admitted according to the criteria above.
2. The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Physician and hospital claims for hospital observation services are subject to post payment review to verify medical necessity.

C. Coverage Limitations

Medicaid pays physicians all-inclusive "global" fees for outpatient surgical procedures. Physicians may not bill Medicaid separately for hospital observation services preceding, or subsequent to, outpatient surgery.

Please note that an attending physician may bill Medicaid only once per day per patient for "Evaluation and Management Services" including physician non-emergency outpatient visit.

The following table gives examples of appropriate physician billing for several common hospital scenarios. The billing instructions under the headings, "PHYSICIAN MAY BILL...," do not necessarily include all services for which the physician may bill. For instance, they do not state that you may bill for interpretation of X-rays or diagnostic tests. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for billing related evaluation and management services.

Patient is admitted to observation	**Patient Is**	**Physician may bill for Tuesday services:**	**Physician may bill for Wednesday services:**
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care discharge day management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and management services
Tuesday, 3:00 PM, after exam in Emergency Department-emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; patient was discharged Tuesday

251.000 Surgery 12-15-14

There are certain medical and surgical procedures that are not covered without prior authorization either because of federal requirements or because of the elective nature of the surgery.

Surgeons must include ten (10) days of inpatient postoperative care as part of their surgical charges. Surgeons will not be allowed to bill Medicaid separately for surgery and the follow-up care visits associated with the surgery except in the following instances:

A. The physician doing inpatient postoperative visits when he or she did not perform the surgery and is seeing the patient for a condition not related to the surgery. This "condition not related to surgery" must be reflected in the primary detail ICD diagnosis code billed with the visit.

B. Diagnostic endoscopy procedures.

Postoperative care includes care given by a physician other than the surgeon when the care is for the same condition that necessitated the surgery. If an attending physician consults with a surgeon and following the surgery, resumes the patient's care, the attending physician may not bill Medicaid for post-op care rendered during the first ten (10) days after the surgery.

251.100 Co-Surgery 2-1-06

Covered surgical procedures performed simultaneously on a Medicaid beneficiary are covered as separate procedures. Refer to Section 292.451 for billing instructions.

251.110 Assistant Surgery 8-1-21

For medical payment to be made to an assistant surgeon, the physician who wishes to use an assistant surgeon must obtain prior authorization from the DHS or its designated vendor. Assistant surgeon services are reimbursed only when provided by a physician. See Section 261.000 of this manual for prior authorization instructions. This provision applies to all surgery.

251.120 Surgical Residents 2-1-06

In order for surgeons enrolled in the Arkansas Medicaid Program to be reimbursed for services provided by a surgical resident, the surgeon must be physically present in the operating room with the resident while services are being provided.

251.200 Surgical Procedures

251.210 Anesthesia 9-15-12

The Arkansas Medicaid Program will reimburse either the Anesthesiologist (M.D.) or the Certified Registered Nurse Anesthetist (C.R.N.A.) for anesthesia services provided to eligible Medicaid beneficiaries during surgery and/or medical treatment within the limits of the Medicaid Program. The same limits that apply to the physicians for surgical procedures also apply to the anesthetist. Refer to Section 262.000 in this manual for procedures that require prior authorization and refer to the Billing Procedures section of this manual for non-payable procedure codes. Also refer to Sections 292.440 and 292.447 for special billing procedures and for information to determine anesthesia values.

The following anesthetics are payable when administered by the physician or surgeon in connection with performing his own medical or surgical procedures in the office or medical

facility: Caudal, Epidural, Pericervical, Pudendal, Spinal and Twilight (Scopolamine and Demerol - individually or in combination).

251.220 Elective Abortions 2-1-22

Only medically necessary abortions are covered by Arkansas Medicaid. 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, defined under Ark. § Code Ann. 5-14-103 and § 5-22-202, as certified in writing by the woman's attending physician.

A. All abortions require prior authorization. A Certification Statement for Abortion (DMS-2698) must be completed prior to performing the procedure and is required for requesting prior authorization and billing. **View or print form DMS-2698**.

B. Other required documentation includes patient history and physical exam records. The physician performing the abortion is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. Refer to Section 292.410 for other billing instructions.

C. For abortions when the life of the mother would be endangered if the fetus were carried to term, prior authorization (PA) requests must be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting a review.**

D. Abortions for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services Utilization Review Section. **View or print the Utilization Review contact information.** Refer to Section 261.260 for instructions on requesting PA.

E. Payable Abortion Procedure Codes

1. For Professional or Outpatient Abortion Claims, the following codes are required:

   View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

2. For inpatient hospital facility Abortion Claims, the provider must use the following codes:

   a. 10A00ZZ – Abortion of Products of Conception, Open Approach
   b. 10A03ZZ – Abortion of Products of Conception, Percutaneous Approach
   c. 10A07Z6 – Abortion of Products of Conception, Vacuum, Via Natural or Artificial Opening
   d. 10A07ZW – Abortion of Products of Conception, Laminaria, Via Natural or Artificial Opening
   e. 10A07ZX – Abortion of Products of Conception, Abortifacient, Via Natural or Artificial Opening
   f. 10A07ZZ – Abortion of Products of Conception, Via Natural or Artificial Opening

251.230 Cochlear Implant and External Sound Processor Coverage Policy 2-1-22

The Arkansas Medicaid Program provides coverage for cochlear implantation and the external sound processor for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. (See Section 261.120 for prior authorization requirements and Section 292.801 for billing protocol.)

A. Cochlear Implants

Cochlear Implants are covered through the Arkansas Medicaid Physician or Prosthetics Program for eligible Medicaid beneficiaries under the age of twenty-one (21) years through the Child Health Services (EPSDT) Program when prescribed by a physician.

The cochlear implant device, implantation procedure, the sound processor and other necessary devices for use with the cochlear implant device require *prior authorization* from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

The replacements of lost, stolen or damaged external components (not covered under the manufacturer's warranty) are covered when prior authorized by Arkansas Medicaid.

Reimbursements for manufacturer's upgrades will not be made. An upgrade of a speech processor to achieve aesthetic improvement, such as smaller profile components or a switch from a body worn, external sound processor to a behind-the-ear (BTE) model or technological advances in hardware, are considered not medically necessary and will not be approved.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*Denotes paper claim required

B. Speech Processor

Arkansas Medicaid will not cover new generation speech processors if the existing one is still functional. Consideration of the replacement of the external speech processor will be made **only** in the following instances:

1. The beneficiary loses the speech processor.
2. The speech processor is stolen.
3. The speech processor is irreparably damaged.

Additional medical documentation supporting medical necessity for replacement of external components should be attached to any requests for prior authorization.

C. Personal FM Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available by any other source (i.e., educational services). The federal Individuals with Disabilities Education Act (IDEA) requires public school systems to provide FM systems for educational purposes for students starting at age three (3). Arkansas Medicaid does not cover FM systems for children who are eligible for this service through IDEA.

A Request for Prior Authorization may be submitted for medically necessary FM systems **(procedure code for use with cochlear implant)** that are not covered through IDEA; each request must be submitted with documentation of medical necessity. These requests will be reviewed on an individual basis.

D. Replacement, Repair, Supplies

The repair and/or replacement of the cochlear implant external speech processor and other supplies (including batteries, cords, battery charger and headsets) will be covered in accordance with the Arkansas Medicaid policy for the Physician and Prosthetics programs. The covered services must be billed by an Arkansas Medicaid Physician or Prosthetics provider. The supplier is required to request prior authorization for repairs or replacements of external implant parts.

251.240 Cosmetic Surgery 3-15-05

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 261.100 of this manual for instructions for obtaining prior authorization.

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

B. Otoplasty (lop ears). Medicaid covers prior-authorized surgical correction of lop ears and similar congenital abnormalities when performed on children before the 21st birthday. Evaluation of the medical necessity of such procedures includes reviewing the attending physician's statement regarding the degree to which such conditions are detrimental to the patient's psychological well being.

C. Rhinoplasty. Medicaid covers prior-authorized surgical correction involving rhinoplasty procedures when performed on children before the 21st birthday. Evaluation of the medical necessity of such procedures includes reviewing the attending physician's statement regarding the degree to which such conditions are detrimental to the patient's physical and functional abilities.

251.250 Vagus Nerve Stimulation 6-1-22

The Arkansas Medicaid Program covers vagus nerve stimulation therapy, device, and procedure under the Hospital Outpatient program. Vagus nerve stimulation therapy device and procedure require prior authorization for medical necessity. Refer to the Hospital manual for further information regarding prior authorization and outpatient hospital billing instruction.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

251.260 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.) 10-13-03

Arkansas Medicaid provides coverage of E.S.W.L. Prior authorization is not required for the procedure. Please refer to Section 272.400 for the reimbursement methodology and Section 292.530 for special billing instructions.

251.270 Bariatric Surgery for Treatment of Morbid Obesity 11-1-09

Bariatric Surgery for treatment of morbid obesity is payable under the Arkansas Medicaid Program with prior authorization. Refer to Section 261.100 of this manual for instructions on obtaining prior authorization.

Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma, pulmonary and circulatory insufficiencies and complications related to treatment of other medical conditions.

Requirements for Bariatric Surgery

A. The patient must be between 18 and 65 years of age.

B. The beneficiary has a documented body-mass index >35 and has at least one co-morbidity related to obesity.

C. The beneficiary must be free of endocrine disease as supported by an endocrine study consisting of a T3, T4, blood sugar and a 17-Keto Steroid or Plasma Cortisol.

D. Under the supervision of a physician the beneficiary has made at least one documented attempt to lose weight in the past. The medically supervised weight loss attempt(s) as defined above must have been at least six months in duration.

E. Medical and psychiatric contraindications to the surgical procedure have been ruled out (and referrals made as necessary)

1. A complete history and physical, documenting
   a. beneficiary's height, weight, and BMI
   b. the exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome,
2. A psychiatric evaluation no more than three months prior to the requesting authorization. The evaluation should address these issues:
   a. Ability to provide, without coercion, informed consent,
   b. family and social support,
   c. patient ability to comply with the postoperative care plan and, identify potential psychiatric contraindications

Note: Documentation female candidates have received counseling regarding potential birth defects from nutritional deficiencies if they should become pregnant during the weight stabilization period following bariatric surgery. Documentation all candidates have been informed of possible adverse events related to the surgery.

Covered Procedures

See Section 261.100 for prior authorization instructions and the Arkansas Medicaid Physicians fee schedule for covered procedure codes.

- Open and laparoscopic Roux-en-Y gastric bypass (RYGBP)
- Open and laparoscopic Biliopancreatic Diversion with Duodenal Switch (BPD/DS)
- Laparoscopic adjustable gastric banding (LAGB) Vertical banded gastroplasty
- Gastric Bypass

Non-covered Procedures

The following bariatric surgery procedures are non-covered:

- Open adjustable gastric banding
- Open and laparoscopic sleeve gastrectomy

251.280 Hysterectomies 7-15-12

Hysterectomies, except those performed for malignant neoplasm, carcinoma in-situ and severe dysplasia will require prior authorization regardless of the age of the beneficiary. (See Section 261.100 of this manual for instructions for obtaining prior authorization.) Those hysterectomies performed for carcinoma in-situ or severe dysplasia must be confirmed by a tissue report. The tissue report must be obtained prior to surgery. Cytology reports alone will not confirm the above two diagnoses, nor will cytology reports be considered sufficient documentation for performing a hysterectomy. Mild or moderate dysplasia is not included in the above and any hysterectomy performed for mild or moderate dysplasia will require prior authorization.

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

The patient or her 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.** Copies of this form can be ordered from the Arkansas Medicaid fiscal agent according to the procedures in Section III.

If an individual has a physical disability and signs the consent form 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

Please note that the acknowledgement statement must be submitted with the claim for payment. The Medicaid agency will not approve any hysterectomy for payment until the acknowledgement statement has been received.

If the patient needs the Acknowledgement of Hysterectomy Information Form (DMS-2606) in an alternative format, such as large print, contact our Americans with Disabilities Coordinator. **View or print the Americans with Disabilities Coordinator contact information.**

For hysterectomies for the mentally incompetent, 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.

B. Random Audits of Hysterectomies

All hysterectomies paid 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 a 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.

C. Hysterectomies Performed for Sterilization

Medicaid **does not cover** any hysterectomy performed for the sole purpose of sterilization.

251.290 Sterilization 11-1-08

A. Non-therapeutic sterilization means any procedure or operation for which the primary purpose is to render an individual permanently incapable of reproducing. Non-therapeutic sterilization is neither (1) a necessary part of the treatment of an existing illness or injury nor (2) medically indicated as an accompaniment of an operation of the female genitourinary tract. The reason 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.

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

B. Federal regulations are very explicit concerning coverage of non-therapeutic sterilization. Therefore, Medicaid reimbursement will be made only when the following conditions are met:

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

2. The person is mentally and legally competent to give informed consent.
3. The person is 21 years of age or older at the time informed consent is obtained.
4. The person to be sterilized shall not be an institutionalized individual. The regulations define "institutionalized individual" as a person who is:
   a. involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility including those for a mental illness,

      or

   b. confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

   If you have any questions regarding this requirement, contact the Arkansas Medicaid Program **before** the sterilization.
5. The person has been counseled, both orally and in writing, concerning the effect and impact of sterilization and alternative methods of birth control.
6. Informed consent and counseling must be properly documented. Only the official Form DMS-615 (4/96) - Sterilization Consent Form, properly completed, complies with documentation requirements. **View or print form DMS-615.** If the patient needs the Sterilization Consent Form (DMS-615) in an alternative format, such as large print, contact the Americans with Disabilities Act Coordinator. **View or print the Americans with Disabilities Act Coordinator contact information.**
   a. By signing the consent form, the patient certifies that she or he 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, you should contact the Arkansas Medicaid Program for clarification BEFORE the sterilization procedure is performed.
   b. 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.
   c. A copy of the consent form given to the recipient 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.
   d. 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. In keeping with federal interpretation of federal requirements, the State has defined "shortly before" as one week (seven days) prior to the performance of the sterilization procedure.

   The physician's signature on the consent form must be an original signature and not a rubber stamp.
7. Informed consent may not be obtained while the person to be sterilized is:
   a. In labor or during childbirth,
   b. Seeking to obtain or obtaining an abortion, or
   c. Under the influence of alcohol or other substances that affect the individual's state of awareness.
8. The sterilization must be 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:

a. 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

b. 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.

9. The person is informed, prior to any sterilization discussion or counseling, that 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.

10. If the person is physically disabled and signs the consent form 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. If a claim is received which does not have the statement attached, the claim will be denied.

C. A copy of the properly completed Sterilization Consent Form DMS-615, with all items legible, must be attached to each claim submitted from each provider before payment may be approved. Providers include hospitals, 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 hospital, anesthesiologist and assistant surgeon.**

Though prior authorization is not required, an improperly completed Sterilization Consent Form DMS-615 results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met.

View or print form DMS-615 and checklist.

251.300 Organ Transplants 8-1-21

A. All organ transplants require prior approval.

1. Medicaid covers bone marrow, corneal, heart, kidney, liver and lung transplants for eligible Medicaid beneficiaries of all ages.

2. Medicaid covers pancreas/kidney transplants and skin transplants for burns for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

3. Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

B. Medicaid covers physicians' inpatient services only on days that Medicaid covers the hospital's inpatient services; therefore, inpatient hospital stays for corneal, kidney, pancreas/kidney and skin transplants are all subject to Medicaid Utilization Management Program (MUMP) precertification.

C. Additionally, for inpatient stays related to all other transplants:

1. Hospital days in excess of transplant length of stay averages require medical review and approval by DHS or its designated vendor.

2. Reference sources for organ transplant length-of-stay (LOS) averages are the Centers for Medicare and Medicaid Services (CMS) Acute Inpatient Prospective

Payment System (PPS) – using the "Arithmetic Mean LOS" method – or the most recently published Medicare National Coverage Decisions.

D. Post-operative care (inpatient or outpatient) for ten (10) days is included in Medicaid's coverage of each transplant procedure. In the sections that follow, references to "post-operative care" and "follow-up care" includes the ten (10)-day post-operative care rule.

E. Refer to Sections 261.100 and 261.230 for prior approval procedures.

F. Refer to Sections 292.820 through 292.832 for billing instructions.

251.301 Corneal Transplants 3-15-05

Medicaid covers physician services associated with corneal transplants, subject to the same regulatory guidelines and benefit limits as other covered physician services.

251.302 Kidney (Renal) Transplants 3-15-05

A. If a candidate for a renal transplant is not a Medicare beneficiary but is eligible under the Medicaid Program, Medicaid will cover a prior-approved renal transplant.

B. Covered physician services related to renal transplantation include:

1. Removal of the organ from a living donor.
2. Transplanting the kidney into the receiver.
3. Follow-up care.

C. Physician services for renal transplants are subject to the same regulatory guidelines and benefit limits as other covered physician services for both the donor and the receiver.

251.303 Heart Transplants 8-1-21

A. Medicaid covers heart transplants for beneficiaries of all ages.

B. Covered physician services related to the transplant include:

1. Transplanting the heart into the receiver.
2. Postoperative care.

C. Heart transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's medical review. Refer to Section 251.300, part C.

251.304 Liver and Liver/Bowel Transplants 8-1-21

A. Medicaid covers liver transplants for beneficiaries of all ages.

B. Medicaid covers liver/bowel transplants for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program.

C. Covered physician services related to the transplant include:

1. The surgical procedure to remove a partial liver from a living donor (when applicable).
2. Physician services for transplanting the liver into the receiver.

3. Postoperative care (including postoperative care for the living donor of a partial liver, when applicable).

D. Liver and liver/bowel transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's. Refer to Section 251.300, part C.

251.305 Bone Marrow Transplants 3-15-05

A. Medicaid covers bone marrow transplants for beneficiaries of all ages.

B. Covered physician services related to bone marrow transplantation include:

1. The bone marrow harvesting procedures.
2. Transplanting the bone marrow into the receiver.
3. Postoperative care for the donor and the receiver.

C. Bone marrow transplants are exempt from the MUMP and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge.*

251.306 Lung Transplants 8-1-21

A. Medicaid covers lung transplants for beneficiaries of all ages.

B. The following list of medical diagnoses or diseases are those in which it is believed patients could benefit significantly from a lung transplant when it has been determined the disease has reached an end-stage cycle or level:

1. Pulmonary Vascular Disease
2. Primary Pulmonary Hypertension
3. Eisenmenger's Syndrome (ASD, VSD, PVA, Truncus, Other Complex Anomalies)
4. Pulmonary Hypertension secondary to Thromboembolism
5. Obstructive Lung Disease
6. Emphysema (idiopathic)
7. Emphysema (alpha antitrypsin deficiency)
8. Bronchopulmonary Dysplasia
9. Post-Transplant Obliterative Bronchiolitis
10. Bronchiolitis Obliterans Organizing Pneumonia (BOOP)
11. Restrictive Lung Disease
12. Idiopathic Pulmonary Fibrosis
13. Sarcoidosis
14. Asbestosis
15. Eosinophilic Granulomatosis
16. Desquamative Interstitial Pneumonitis
17. Lymphangioleiomyomatosis

C. Covered physician services related to the transplant include:

1. Transplanting the organ into the receiver.
2. Postoperative care.

D. Lung transplants are exempt from the Medicaid Utilization Management Program (MUMP) and the annual benefit limit for inpatient hospital services. *Services excluded from the annual benefit limit and the MUMP are the services provided from the date of the transplant procedure to the date of discharge,* subject to any limitations imposed by the current published Medicare National Coverage Decisions or DHS or its designated vendor's medical review. Refer to Section 251.300, part C.

251.307 Skin Transplants 3-15-05

Medicaid covers skin transplants for burns of greater than 70% of the body surface area, with more than 50% of that area being full-thickness or third-degree burns, for beneficiaries under age 21 in the Child Health Services (EPSDT) Program.

A. Covered physician services related to the skin transplant include:

1. Removal of the skin from the donor site.
2. Transplanting the skin.
3. Postoperative care.

B. Skin transplants are subject to the MUMP.

251.308 Pancreas/Kidney Transplants 3-15-05

A. Medicaid covers pancreas/kidney transplants for beneficiaries under age 21 in the Child Health Services (EPSDT) Program who have a diagnosis of juvenile diabetes with renal failure.

B. Covered physician services related to pancreas/kidney transplants include:

1. Transplanting the pancreas/kidney into the receiver.
2. Postoperative care.

C. Pancreas/kidney transplants are subject to the MUMP.

252.000 Reserved 8-1-18

252.100 Reserved 8-1-18

252.200 Reserved 8-1-18

253.000 Reserved 4-1-14

254.000 Enterra Therapy for Treatment of Gastroparesis 2-1-22

A. Arkansas Medicaid covers Enterra, implantable neurostimulator therapy.

B. Coverage of Enterra therapy is limited to individuals ages eighteen (18) through sixty-nine (69) with diabetic and idiopathic gastroparesis (**View ICD Codes.**).

1. Service includes the implantable neurostimulator electrode(s) and the neurostimulator pulse generator.
2. Implantation procedures for neurostimulator pulse generator and the neurostimulator electrodes are covered as inpatient surgical procedures.
   a. The surgical procedures require prior authorization (PA) by DHS or its designated vendor.

      View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.
   b. An approval letter from the Institutional Review Board is required. Patient's record must include documentation that further total parental nutrition (TPN) therapy is not an option.
3. Procedure for revision or removal of the peripheral neurostimulator electrodes does not require PA, but claim will be manually reviewed prior to reimbursement.

C. See **Section 292.880** of this manual for procedure codes and billing instructions.

255.000 Ultrasonic Osteogenic Stimulator for Treatment of Non-Union Fractures (Exogen) 2-1-06

A. Effective for dates of service on and after March 1, 2005, Arkansas Medicaid added coverage of ultrasonic osteogenic stimulator (Exogen) for the treatment of non-union fractures for beneficiaries of all ages.

B. The prior authorization (PA) process is the same as for all durable medical equipment (DME) procedure codes that require PA. The patient's physician must prescribe the device and make a referral to the DME provider.

Prior authorization request requires documentation of the following:

1. A minimum of two sets of radiographs, separated by a minimum of 90 days, and obtained prior to starting treatment with the osteogenic stimulator.
2. Multiple views of the fracture site for each radiograph.
3. The physician's written statement that there has been no clinically significant evidence of fracture healing in the interval between the two sets of radiographs.

C. Prior authorization of the device may be approved for up to 180 days. If the need for the device extends beyond 180 days, an additional PA is required. Documentation which includes updated evaluations must be submitted with the PA request.

D. Coverage of the device does not include:

1. Non-unions of the skull, vertebrae and those tumor-related.
2. Concurrent use with other non-invasive osteogenic devices

256.000 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

A. Arkansas Medicaid covers wireless endoscopy capsule for diagnosis of occult gastrointestinal bleeding in the anemic patient under the conditions listed below.

1. The site of the bleeding has not been identified by previous gastrointestinal endoscopy, colonoscopy, push endoscopy or other radiological procedures.
2. An abnormal x-ray of the small intestine is documented without an identified site of bleeding by endoscopic means.
3. Diagnosis of angiodysplasias of the GI tract is suspected, or

4. Individuals with confirmed Crohn's disease to determine whether there is involvement of the small bowel.

B. This procedure is covered for individuals of all ages based on medical necessity when performed with FDA-approved devices and by providers formally trained in upper and lower endoscopies.

C. Documentation of medical necessity requires a primary detail diagnosis of one of the following ICD diagnosis codes (**View ICD Codes**.).

D. GI tract capsule endoscopy is not covered in the patient who has not undergone upper GI endoscopy and colonoscopy during the same period of illness in which a source of bleeding is not revealed.

E. This test is covered only for those beneficiaries with documented continuing blood loss and anemia secondary to bleeding.

F. See **Section 292.890** for procedure code and billing instructions.

257.000 Tobacco Cessation Products and Counseling Services 7-1-22

Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without Prior Authorization (PA) to eligible Medicaid clients. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

A. Providers may participate by prescribing covered tobacco cessation products. Reimbursement for tobacco cessation products is available for all prescription and over the counter (OTC) products and subject to be within U.S. Food and Drug Administration prescribing guidelines.

B. Counseling by the prescriber is required to obtain initial Prior Authorization (PA) coverage of the products. Counseling consists of reviewing the Public Health Service (PHS) guideline-based checklist with the client. The prescriber must retain the counseling checklist in the client records for audit. **View or print the Arkansas Be Well Referral Form.**

C. Counseling procedures do not count against the visit limits allowed per State Fiscal Year (SFY/July 1 to June 30), but they are limited to no more than two (2) 15 minute units and two (2) thirty minute units for a maximum allowable of four (4) units per SFY.

D. Counseling sessions can be billed in addition to an office visit or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit. These sessions do not require a Primary Care Provider (PCP) referral.

E. If the client is under eighteen (18) years of age, and the parent or legal guardian smokes, the parent or legal guardian can be counseled as well, and the visit billed under the minor client's Medicaid number. The provider cannot prescribe medications for the parent or legal guardian under the minor client's Medicaid number. A parent or legal guardian session will count towards the four (4) counseling sessions limit described in Section C above.

F. Additional prescription benefits will be allowed per month for tobacco cessation products and will not be counted against the monthly prescription benefit limit. Tobacco cessation products are not subject to co-pay.

G. Arkansas Medicaid will provide coverage of prescription and over the counter (OTC) smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence - 2008 Update: A Clinical Practice Guideline" published by the Public Health Service in May 2008 or any subsequent modification of such guideline.

H. Refer to Section 292.900 for procedure codes and billing instructions.

258.000 Hyperbaric Oxygen Therapy (HBOT) 8-1-21

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy.

Hyperbaric oxygen therapy (HBOT) involves exposing the body to oxygen under pressure greater than one atmosphere. Such therapy is performed in specially constructed hyperbaric chambers holding one (1) or more patients; although oxygen may be administered in addition to the hyperbaric treatment. Patients should be assessed for contraindications such as sinus disease or claustrophobia prior to therapy. In some diagnoses, hyperbaric oxygen therapy (HBOT) is only an adjunct to standard surgical therapy. These indications are taken from "The Hyperbaric Oxygen Therapy Committee Report" (2003) of The Undersea and Hyperbaric Medical Society (Kensington, MD).

Hyperbaric oxygen therapy (HBOT) prior authorizations will be issued by DHS or its designated vendor. All hyperbaric oxygen therapy (HBOT) will require prior authorization, except in emergency cases such as for air embolism or carbon monoxide poisoning, in which case, post authorization will be allowed per protocol (See Section 261.100). Prior authorization will be for a specific number of treatments. Further treatments will require reapplication for a prior authorization. **View or print contact information to obtain the DHS or designated vendor step-by-step process for HBOT prior authorization requests.**

NOTE: When approved, only one authorization will be issued. The prior authorization and the number of approved HBOT treatments must be shared with the facility provider so that both the physician and the facility may be reimbursed for the number of approved HBOT sessions. Additionally, if more HBOT sessions are required, a new prior authorization must be requested and the above process followed. A new prior authorization will be assigned for any additional sessions approved. The prior authorization information between the physician and the facility shall be reciprocal if the facility acquires the prior authorization.

The following table provides the diagnosis requirements, description of the problem, and number of treatments.

Diagnosis	Description	Number of Treatments
View ICD Codes.	Air or Gas Embolism	10
View ICD Codes.	Decompression Sickness	10
View ICD Codes.	Carbon Monoxide Poisoning	5
View ICD Codes.	Clostridial Myositis and Myonecrosis (Gas Gangrene)	10
View ICD Codes.	Crush injuries, compartment syndrome, other acute traumatic peripheral ischemias	6
View ICD Codes.	Enhancement of healing in selected problem wounds; diabetic foot ulcers, pressure ulcers, venous stasis ulcers; only in severe and limb or life-threatening wounds that have not responded to other treatments, particularly if ischemia that cannot be corrected by vascular procedures is present	30
View ICD Codes.	Intracranial abscess, multiple abscesses, immune compromise, unresponsive	20

Diagnosis	Description	Number of Treatments
View ICD Codes.	Necrotizing Soft Tissue Infections, immune compromise	30
View ICD Codes.	Refractory osteomyelitis after aggressive surgical debridement	40
View ICD Codes.	Delayed Radiation Injury	60
View ICD Codes.	Compromised skin grafts and flaps	20
View ICD Codes.	Thermal burns > 20% TSBA +/or involvement of hands, face, feet or perineum that are deep, partial or full thickness injury	40
View ICD Codes.	Compartment syndrome, impending stage fasclotomy not required	1
View ICD Codes.	Problem wounds after primary management	14

Refer to Section 292.860 of this manual for billing instructions.

260.000 PRIOR AUTHORIZATION

261.000 Obtaining Prior Authorization of Restricted Medical and Surgical Procedures 8-1-21

Certain medical and surgical procedures are covered only with prior authorization (PA). Refer to sections 261.100 through 261.220 for instructions on requesting PA.

261.100 Obtaining Prior Authorization 8-1-21

A. Prior authorization determinations obtained through DHS or its designated vendor are made in accordance with established medical and administration criteria combined with the professional judgment of physician advisors. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Payment for prior authorized services is in accordance with Federal regulations.

B. It is the responsibility of the physician who will perform the procedure to initiate the prior authorization request.

(IF REQUEST IS MADE BY PHONE, ALL CALLS WILL BE TAPE RECORDED)

1. If surgery is involved, a copy of the authorization will be sent to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting physician or DHS or its designated vendor to verify prior authorization has been granted.

2. It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved. The Medicaid program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.

C. Consulting physicians are responsible for contact DHS or its designated vendor to have their required or restricted procedures added to the PA file. They will be given the prior authorization information at the time of the request on those cases that are approved. A letter verifying the PA will be sent to the consultant upon request.

D. Post-authorization will be granted only for emergency procedures or retroactively eligible beneficiaries. Requests for emergency procedures must be requested on the first working day after the procedure has been performed. In cases of retroactive eligibility, DHS or its designated vendor must be contacted for post-authorization within sixty (60) days of the eligibility card issue/add date.

E. Prior authorization is not required for services performed by an anesthesiologist. Anesthesiologists/anesthetists must continue to attach required documentation to their claims, such as sterilization consent forms for tubal ligation or vasectomy or the acknowledgment of informed consent for a hysterectomy.

F. PRIOR AUTHORIZATION OF SERVICE DOES NOT GUARANTEE ELIGIBILITY FOR A BENEFICIARY. PAYMENT IS STILL SUBJECT TO VERIFICATION THAT THE BENEFICIARY WAS ELIGIBLE AT THE TIME SERVICES ARE PROVIDED.

G. In cases involving a hysterectomy, documentation must be provided that reflects the acknowledgement statement was signed prior to surgery or the attending physician must certify in writing:

1. The individual was already sterile, stating the cause of sterility; or
2. The hysterectomy was performed under a life-threatening emergency in which the physician determined prior acknowledgement was not possible. The physician must include a clear description of the emergency.
3. THIS DOCUMENTATION MUST BE ATTACHED TO THE CLAIM FOR PAYMENT. The documentation must be reviewed and approved by the Medicaid Program before payment can be considered. ALL guidelines must be met in order for payment to be made.

View or print Medicaid Utilization Review contact information.

261.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 8-1-21

A. Providers performing surgical procedures that require prior authorization are allowed 60 days from the date of service to obtain a PA **if the beneficiary is under age twenty-one (21)**.

B. The following post-procedural authorization process must be followed when requesting an authorization for the procedures in Section 262.000.

1. If requested by phone the call must be made by a physician or a physician's office nurse and will be recorded.
2. If the provider receives only the Medicaid identification number from the beneficiary and is unable to obtain the actual card to validate the eligibility dates, the information may be obtained by calling the Provider Assistance Center. **View or print the contact information for provider assistance.**
3. Consulting physicians are responsible for contacting DHS or its designated vendor to have their required or restricted procedures added to the PA file. They will be given the prior authorization on cases that are approved. A letter verifying the PA will be sent to the consultant upon request. All patient identification information and medical information related to the necessity of the procedure requiring authorization must be provided.

C. Providers must obtain prior authorization for procedures requiring approval in order to prevent risk of denial due to lack of medical necessity.

This policy applies only to those eligible Medicaid beneficiaries under age twenty-one (21). This policy does not alter policy currently applicable to retroactive-eligible beneficiaries.

261.120 Prior Authorization of Cochlear Implant, External Sound Processor and Repair/Replacement Supplies 2-1-22

A. Arkansas Medicaid provides coverage for cochlear implantation and for the external sound processor for beneficiaries under age 21 in the Child Health Services (EPSDT) Program. Prior authorization by AFMC is required.

B. A written request signed by the physician performing the procedure is required. The request must be accompanied by medical documentation to support medical necessity. See Section 261.100 for prior authorization instructions.

C. Prior Authorization for Repair and/or Replacement of Cochlear Implant External Components and Supplies

A request for prior authorization of a medically necessary FM system (for use with cochlear implant) and replacement cochlear implant parts requires a paper submission to the Arkansas Foundation for Medical Care (AFMC) using **DMS-679-A**. **(View or print form DMS-679-A**.) All documentation supporting medical necessity should be attached to the form. The provider will be notified in writing of the approval or denial of the request for prior authorization.

Prior authorization does not guarantee payment for services or the amount of payment for services. Eligibility for and payment of services are subject to all terms, conditions and limitations of the Arkansas Medicaid Program. Documentation must support medical necessity. The provider must retain all documentation supporting medical necessity in the beneficiary's medical record. See Section 261.100 of this manual for prior authorization procedures. Refer to Section 292.801 for further billing instructions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

261.200 Obtaining Prior Authorization from the Division of Medical Services Utilization Review Unit 4-1-14

View or print the Division of Medical Services Utilization Review contact information.

261.210 Prior Authorization of Ambulatory Infusion Device 8-1-21

A. Arkansas Medicaid covers an ambulatory infusion device when it is provided by the physician and prior authorized. This device is covered only when services are provided to Medicaid beneficiaries receiving chemotherapy, pain management or antibiotic treatment in the home. Refer to Section 292.430 for the procedure code and billing instructions. To obtain prior authorization, the physician providing the equipment must complete and sign Form DMS-679, Medical Equipment Request for Prior Authorization and Prescription. **View or print form DMS-679 and instructions for completion.** The original and first copy of the form 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 prior authorization requests.**

B. Approvals are authorized for a maximum of six (6) months (180 days). If services are needed for a longer period, a new request must be submitted.

C. The effective date of the prior authorization is the date the patient begins use of the equipment or the date following the expiration date of the previous prior authorization approval.

D. Denied requests are returned to the provider indicating the reason for denial.

261.220 Prior Approval of Transplant Procedures 8-1-21

A. The attending physician is responsible for obtaining a Prior Approval letter for organ transplant evaluations and for organ transplants.

1. The attending physician must request a Prior Approval Letter from the Utilization Review Section for a transplant evaluation, naming the facility at which the evaluation is to take place and the physician who will conduct the evaluation. **View or print the UR Section contact information.** This request must include the following:
   a. History and physical and supporting documentation;
   b. Previous treatment;
   c. Copy of the most recent hospitalization;
   d. Name of proposed facility where patient will be referred for transplant; and,
   e. Third-party insurance information, when applicable.
2. Utilization Review reviews the physician's request for transplant evaluation and forwards its approval to the facility at which the referring physician has indicated the evaluation will take place.
3. A request for the transplant procedure by the evaluating facility is sent to Utilization Review, including the results of the examination.
4. The request and its supporting documentation is reviewed by DHS or its designated vendor for a determination of approval or denial.
5. The requesting physician and the beneficiary are advised of the determination by letter.

B. The physician is responsible for distributing documentation of prior approval to the hospital and to the other participating providers, such as the anesthetist, assistant surgeon, etc.

261.230 Reconsideration for Denied Prior Approvals 10-1-06

A request for administrative reconsideration of a denied prior approval must be in writing and sent to AFMC within 35 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed or delivered by hand. Faxed or emailed requests will not be accepted.

261.231 Beneficiary Appeal Process for Denied Prior Approvals 10-1-06

When DMS or its designee (AFMC in this case) denies a request for prior approval of a transplant or transplant evaluation, the beneficiary may appeal the denial and request a fair hearing.

A. An appeal request must be in writing.

B. The appeal request must be received by the Appeals and Hearings Section of the Department of Human Services (DHS) within 30 days of the date on the provider notification denial letter from the Utilization Review Section or AFMC**. View or print the Department of Human Services, Appeals and Hearings Section contact information.**

261.240 Prior Authorization of Hyaluronon (sodium hyaluronate) Injection 4-1-14

Refer to Section 261.200 for the Division of Medical Services Utilization Review prior authorization information. Refer to Section 292.950 for billing and special instructions.

261.250 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 2-1-22

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

261.260 Prior Authorization of Elective Abortion of Pregnancy Resulting from Rape or Incest 2-1-22

The following procedures must be followed to obtain prior authorization for elective abortion when pregnancy is the result of rape or incest:

A. The woman's physician must complete the Certification Statement for Abortion, form DMS-2698 (Rev. 8/04) 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. **View or print form DMS-2698**.

1. The completed form DMS-2698 must include the name and address of the patient and be dated before the date of surgery.
2. The patient may sign the Certification Statement for Abortion (form DMS-2698) for herself at eighteen (18) years of age or older.
3. If the patient is under 18 years of age, then a parent or guardian must sign the Certification Statement for Abortion (form DMS-2698). The guardian must furnish a copy of the order appointing him or her guardian, or furnish the letters of guardianship issued by the court clerk.

B. Effective for dates of service on and after August 1, 2004, the physician must fax a completed form DMS-2698, patient history and medical exam records to the Department of Human Services (DHS), Division of Medical Services (DMS), Administrator, Utilization Review Section, for prior authorization of the abortion procedure. **View or print the Division of Medical Services Utilization Review contact information**.

C. DMS Utilization Review Section will convey its decision to the physician within 24 hours; or, if necessary, will request more information for the DMS physician's review. A DMS physician's review is required when UR reviewers deny authorization or need a physician's expertise.

D. The provider must submit the claim and required documentation for payment to the Department of Human Services, Division of Medical Services, Attention: Administrator, Utilization Review. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes. **View or print the Division of Medical Services Utilization Review contact information.**

If the patient needs the Certification Statement for Abortion form (DMS-2698) in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator**. View or print the Americans with Disabilities Act Coordinator contact information.**

Refer to **Section 292.410** for special billing instructions and procedure codes.

262.000 Procedures That Require Prior Authorization 2-1-22

A. The following procedure codes require prior authorization by the Arkansas Foundation for Medical Care (AFMC). (See Section 261.100 of this manual for prior authorization instructions.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

** Denotes that AFMC Prior Authorization is required if these procedure codes are used to save the life of the mother and a Utilization Review Prior Authorization is required in cases for rape or incest. Refer to Sections 251.220, 261.200 and 261.260 for additional information.

B. The following 2013 CPT® Molecular Pathology codes require prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for additional billing information.

C. The following 2012 Molecular Pathology CPT® procedure codes require a prior authorization from the Arkansas Foundation for Medical Care payable effective March 15, 2013. See Section 292.591 for billing additional information.

D. The following procedure codes require prior authorization by the Arkansas Division of Medical Services Utilization Review. (See Section 261.200 for instructions regarding prior authorization with the Division of Medical Services. See Section 292.950 for additional billing information and coverage criteria.)

263.000 Prescription Drug Prior Authorization 2-1-22

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a provider with prescriptive authority. Certain prescription drugs may require prior authorization. It is the responsibility of the prescriber to request and obtain the prior authorization. Refer to the **DHS contracted Pharmacy vendor's website** for the following information:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be completed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

E. Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

To access prior approval of these HCPCS procedure codes when necessary, reference the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor's website**.

263.100 Coverage of Drugs Used for Opioid or Alcohol Use Treatment 2-1-24

Coverage of preferred prescription drugs (preferred on the PDL) for opioid or alcohol use disorder and tobacco cessation are available without prior authorization to eligible Medicaid beneficiaries. Products for other use disorders may still require PA. Additional criteria can be found at the **DHS contracted Pharmacy vendor's website.**

Coverage and Limitations

A. Reimbursement for preferred drugs is available with a valid prescription when prescribed according to FDA approved label.

B. Prescription drugs for treatment of opioid or alcohol use disorder will not count against the monthly prescription benefit limit and are not subject to co-pay.

C. FDA dosing and prescribing limitations apply.

264.000 Appeal Process for Medicaid Beneficiaries 10-13-03

When health services are denied, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within thirty (30) days of the date of the denial notification.

Submit appeals requests to the Department of Human Services Appeals and Hearings Section. **View or print the Department of Human Services Appeals and Hearings Section address.**

270.000 REIMBURSEMENT

271.000 Method of Reimbursement 10-13-03

The methodology used by the Arkansas Medicaid Program to determine reimbursement rates for all physicians, except anesthesiology, is a “fee schedule.” Under the fee schedule methodology, reimbursement is based on the lesser of the billed charge for each procedure or the maximum allowable for each procedure. The maximum allowable for a procedure is the same for all physicians regardless of specialty.

272.000 Special Reimbursement Methods

272.010 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.

272.011 Reserved 12-31-15

272.100 Anesthesia 10-13-03

Payment for anesthesiology is determined by the provider’s base charge times the A.S.A. surgery base units plus one (1) unit for each 15 minutes (or fraction thereof) of surgery plus additional units for other factors such as risk, emergency, etc.

272.200 Assistant Surgery 10-13-03

Assistant surgery payment is 20% of the maximum allowed for the procedure.

272.300 Clinical Lab 10-13-03

Clinical laboratory services, as identified by the Medicare Clinical Lab fee schedule, are reimbursed at the lesser of the 2001 Medicare rate or the amount billed. Clinical lab procedure codes deleted from the Medicare fee schedule are removed from Medicaid reimbursable services. New codes added to the annual Medicare fee schedule are implemented at the current Medicare fee schedule rate.

272.400 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.) 10-13-03

Reimbursement for E.S.W.L. is based on the lesser of the billed charge or the maximum allowable for the procedure. The maximum allowable is the same for all physicians, regardless of specialty. The physician operating the lithotripter is reimbursed for the lithotripsy procedure. The "aftercare" physician, if he or she did not also perform the surgery, is reimbursed by procedure code for the actual services rendered. The operating physician receives 100% of the allowable fee for a single kidney and an additional 50% of the allowable fee for a bilateral procedure. Medicaid will not reimburse the physician for a second treatment if the patient is retreated for the same kidney within 60 days. There is no additional reimbursement available for the use of the machine.

272.500 Lab Panel Fee Reimbursement 10-13-03

The Arkansas Medicaid Program utilizes the application of the lab panel fee reimbursement to claims reflecting fragmented procedures.

Clinical lab codes may be subject to addition and/or deletion in conformance with review and possible quarterly updating by the Centers for Medicare and Medicaid Services (CMS).

272.600 Medication Assisted Treatment for Opioid Use Disorder 9-1-20

Participating MAT providers must bill all components related to MAT guidelines, including but not limited to office visits, lab screening and testing, and required counseling if not referred to another provider.

When a MAT provider meets all conditions outlined within Section 230.000 within the same day, an inclusive payment method may be available for billing the required services (with the exception of lab testing).

When proper treatment according to these guidelines cannot be accomplished within the same day or must encompass referrals for counseling, each provider must bill separately for the actual services he or she provided according to regular fee-for-service billing rules. See Section 292.920 for special billing procedures.

272.700 Multiple Surgery 10-13-03

When more than one surgical procedure is done in an operative session, the primary procedure is payable at 100% of the allowable fee and each secondary procedure is payable at 50% of the allowable fee. This policy applies regardless of the number of surgical sites. No payment is allowed for incidental surgeries.

272.800 Organ Transplant Reimbursement 3-15-05

Medicaid covers certain organ transplants with prior approval. Reimbursement for these services is explained in the following sections.

272.810 Bone Marrow Transplant 3-15-05

A. Reimbursement for bone marrow transplants is 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed. Total reimbursement of all covered charges will not exceed $150,000.00. Reimbursement includes all medical services related to the transplant procedure from the date of admission for the bone marrow transplant procedure to the date of discharge. Both the hospital and physician claims will be manually priced simultaneously. If the combined total exceeds the $150,000.00 maximum, reimbursement for each provider type will be decreased by an equal percentage until the combined total does not exceed the maximum dollar limit.

B. The following services are covered but are not included in the $150,000.00 maximum reimbursement:

1. The medical expenses for a related or unrelated donor. Claims must be submitted as services are provided.
2. Transportation for the Medicaid beneficiary is excluded from the $150,000.00 maximum benefit.

272.820 Corneal, Kidney, and Pancreas/Kidney Transplants 3-15-05

Physician services required for corneal, kidney and pancreas/kidney transplants are reimbursed in the same manner as other inpatient physician services. The beneficiary may not be billed for Medicaid-covered charges in excess of the State's reimbursement.

272.830 Other Covered Transplants 8-1-21

Physician services relating to other covered transplant surgery procedures will be reimbursed at the lesser of negotiated rates or 80% of billed charges, subject to subsequent review to determine that only covered charges are reimbursed.

A. Reimbursement based on billed charges is applicable from the date of the transplant procedure to the date of discharge for covered transplant procedures, subject to applicable Medicaid benefit limits, transplant length of stay averages and medical review.

B. Services provided during dates of readmissions to the same hospital due to complications arising from the original transplant are also reimbursed at the lesser of negotiated rates or 80% of billed charges if determined medically necessary.

C. The beneficiary may not be billed for Medicaid covered charges in excess of the State's reimbursement.

273.000 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. This panel 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.

280.000 HOSPITAL/PHYSICIAN REFERRAL PROGRAM

281.000 Introduction 10-13-03

The intent of the Hospital/Physician Referral Program is four-fold.

First, if the hospital/physician elects to participate in the Hospital/Physician Referral Program, it provides the hospital/physician with a means to identify needy individuals to Arkansas Department of Human Services through written referral and assures the hospital/physician of follow-up contact with interested individuals by Arkansas Department of Human Services.

Second, it provides Arkansas Department of Human Services with a means of reaching needy individuals who might not otherwise be aware of or apply for Medicaid benefits.

Third, it informs needy individuals of possible Medicaid Coverage that would help defray the cost of their medical expense.

Fourth, it enables the hospital/physician to know if application is made and whether or not the patient is Medicaid eligible.

282.000 Hospital/Physician Responsibility 10-13-03

The hospital/physician should inform needy individuals of possible medical assistance available under the Medicaid Program. The hospital/physician should refer all interested individuals to Arkansas Department of Human Services by means of Form DMS-630, Referral for Medical Assistance. **View or print form DMS-630.**

The hospital/physician should be prepared to provide itemized statements on all individuals referred to Arkansas Department of Human Services for potential use in the eligibility determination. The hospital's/physician's representative is responsible for the accurate completion of the Referral Form (DMS-630). After the required information has been entered on the form, the hospital/physician representative will read and explain the authorization section to the client before securing the client's signature. Once the signature is obtained, the hospital/physician representative will sign and date the form and forward it to the local county Human Services office in the client's county of residence.

The County Human Services Office addresses are available from the Arkansas Division of Medical Services.

283.000 County Human Services Office Responsibility 10-13-03

Upon receipt of the Referral Form DMS-630, the local Human Services county office will contact the client. Action must be completed within forty-five (45) days on all applications taken during follow-up. Once a determination has been made, the local county Human Services office will notify the hospital/physician by completing Section 2 of Form DMS-630. The three (3) types of dispositions are:

A. Did Not Respond or No Longer Interested - Client failed to respond to follow-up contact or client stated he or she was no longer interested.

B. Denied - Application taken, client was determined ineligible or eligibility could not be determined.

C. Approved - Application taken, client was determined eligible effective month/day/year.

The client's Medicaid identification card should be issued within thirty (30) days of eligibility determination.

The client is responsible for presenting his/her Medicaid identification card to the hospital/physician for billing purposes each time he or she receives a service.

View or print form DMS-630.

284.130 Ordering Forms 10-13-03

See Section III for instructions on ordering forms.

285.000 Hospital/Physician Referral for Newborns 10-13-03

Federal law mandates Medicaid coverage of infants born to Medicaid beneficiaries for a period of up to 12 months, as long as the mother remains Medicaid-eligible (or would continue to be eligible if still pregnant) and as long as the infant resides with the mother.

A new Hospital/Physician Referral Form for Newborns (DCO-645) must be completed to report the birth of a Medicaid eligible infant. The referring providers must complete and mail the form to the DHS County Office of the mother's residence county within 5 days of the infant's birth, when possible. The form will serve the Division of County Operations as verification of the birth date of the infant as well as documentation of relationship.

A newborn certification for Medicaid eligibility will be made within 5 working days from receipt of the completed Form DCO-700 if the following conditions are met:

A. All vital information and signatures must be on the form when received.

B. It is verified that the mother was a certified Arkansas Medicaid beneficiary at the time of delivery.

C. The DHS County Office has verified by collateral that the child lives with its mother.

The DHS County Office service representative must then complete Part III of the form and return it to the provider within the 5 day period. A DCO-700 will be mailed to the infant's mother to notify her of the application's approval or denial.

View or print form DCO-645 and instructions for completion.

285.100 Ordering Forms 10-13-03

See Section III for instructions on ordering forms.

290.000 BILLING PROCEDURES

291.000 Introduction to Billing 7-1-20

Physician/Independent Lab/CRNA/Radiation Therapy Center providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

292.000 CMS-1500 Billing Procedures

292.100 Procedure Codes

292.110 Billing for Unlisted CPT/HCPCS Procedure Codes 4-1-14

For consideration of any claims with CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form.

Documentation that further describes the service provided must be attached and must include justification for Medical Necessity.

All other billing requirements must be met in order for payment to be approved.

292.111 Reserved 10-1-18

292.200 Physician Place of Service Codes and Modifiers 8-1-07

Arkansas Medicaid's claims processing system recognizes valid national CPT/HCPCS modifiers.

292.210 National Place of Service Codes 7-1-20

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12
Ambulatory Surgical Center	24
Day Care Facility or ADDT Facility	49
Nursing Facility	32
Skilled Nursing Facility	31
Other Locations	99
Independent Laboratory	81
End Stage Renal Disease Treatment Facility	65
Emergency Room	23
Inpatient Psychiatric Facility	51

292.300 Billing Instructions—Paper Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. View or print the Claims Department contact information.

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

292.310 Completion of the CMS-1500 Claim Form 10-1-21

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.

Field Name and Number			Instructions for Completion
	a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b.	RESERVED	Reserved for NUCC use.
		SEX	Not required.
	c.	RESERVED	Reserved for NUCC use.
	d.	INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:		
	a.	EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b.	AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
		PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c.	OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
	d.	CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11.	INSURED'S POLICY GROUP OR FECA NUMBER		Not required when Medicaid is the only payer.
	a.	INSURED'S DATE OF BIRTH	Not required.
		SEX	Not required.
	b.	OTHER CLAIM ID NUMBER	Not required.
	c.	INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
	d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.

Field Name and Number		Instructions for Completion
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14.	DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15.	OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16.	DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for most Physician/Independent Lab/CRNA/Radiation Therapy Center services provided by non-PCPs. Enter the referring physician's name and title.
17a.	(blank)	Not required.
17b.	NPI	Enter NPI of the referring physician.
18.	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See **www.nucc.org** for qualifiers.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 292.200 for codes.
C. EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.

Field Name and Number		Instructions for Completion
	MODIFIER	Modifier(s) if applicable. For anesthesia, when billed with modifier(s) P1, P2, P3, P4, or P5, hours and minutes must be entered in the shaded portion of that detail in field 24D.
E.	DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The “Diagnosis Pointer” is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F.	$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider’s services.
G.	DAYS OR UNITS	For paper claims, including Anesthesia on paper claims, enter the units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail. For electronic claims submission, for Anesthesia services, enter total minutes.
H.	EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I.	ID QUAL	Not required.
J.	RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
	NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25.	FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider’s Medicaid file. If it changes, please contact Provider Enrollment.
26.	PATIENT’S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as “MRN.”
27.	ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28.	TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29.	AMOUNT PAID	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.
30.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

292.400 Special Billing Procedures

292.410 Abortion Procedure Codes 2-1-22

Abortion procedures performed when the life of the mother would be endangered if the fetus were carried to term require prior authorization from DHS or its designated vendor.

Abortion for pregnancy resulting from rape or incest must be prior authorized by the Division of Medical Services, Administrator, and Utilization Review.

The physician must request prior authorization for the abortion procedures and for anesthesia. Refer to Section 260.000 of this manual for prior authorization procedures. The physician is responsible for providing the required documentation to other providers (hospitals, anesthetist, etc.) for billing purposes.

All claims must be made on paper with attached documentation. A completed Certification Statement for Abortion (form DMS-2698 Rev. 8/04), patient history and physical are required for processing of claims.

Use the following procedure codes when billing for abortions.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Refer to Section 251.220 of this manual for policies and procedures regarding coverage of abortions and Sections 261.000, 261.100, 261.200, 261.260 for prior authorization instructions.

292.420 Allergy and Clinical Immunology 2-1-22

Allergy testing is available for all eligible Medicaid beneficiaries regardless of age, but allergy immunotherapy is payable only for eligible children under the Child Health Services (EPSDT) Program.

When charges for children under the Child Health Services (EPSDT) Program are billed to the Medicaid Program for the above services, the health care provider should check "Yes" in the child screening referral section of the claim, Field 24H, on the CMS-1500 claim form only if the service is a direct referral resulting from a Child Health Services (EPSDT) screen (examination). **View a CMS-1500 sample form.**

Appropriate CPT procedure codes should be used when billing for procedures listed in the allergy and clinical immunology section of the CPT book.

Reimbursement of allergy testing will be paid on a "per test" basis. Enter the exact number of tests performed in the "Units" field. Procedure codes must be billed.

Procedure code is not a payable code.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

All laboratory tests done in conjunction with allergy testing or immunotherapy must also be billed by the provider who actually performs the test. Refer to Section 292.600 of this manual for information on specimen collection.

292.430 Ambulatory Infusion Device 2-1-22

Procedure code, modifier **RR**, **Ambulatory Infusion Device**, is payable only when services are provided to patients receiving chemotherapy, pain management or antibiotic treatment in the home.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

One unit of service equals one day. A reimbursement rate has been established and represents a daily rental amount. See Section 261.210 of this manual for Prior Authorization information.

292.440 Anesthesia Services 2-1-22

Anesthesia procedure codes (**00100** through **01999**) must be billed in anesthesia time. Anesthesia modifiers **P1** through **P5** listed under Anesthesia Guidelines in the CPT must be used. When appropriate, anesthesia procedure codes that have a base of four (4) or fewer are eligible to be billed with a second modifier, **"22,"** referencing surgical field avoidance.

Reimbursement for use and administration of local or topical anesthesia is included in the primary surgeon's reimbursement for the surgery that requires such anesthesia. No modifiers or time may be billed with these procedures.

A. Electronic Claims

For electronic claims for Anesthesia services (procedure codes 00100 through 01999), total minutes should be billed in the units field.

B. Paper Claims

If paper billing is required, enter the procedure code, time, and units as shown in Section 292.447. Enter again the number of units (each fifteen (15) minutes of anesthesia equals one (1) time unit) in Field 24G. (See cutaway section of a completed claim in Section 292.447.)

C. The following CPT procedure codes require attachments or documentation.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*****Other documentation may be requested upon review.**

D. Anesthesiologist/anesthetists may bill procedure code for any inpatient or outpatient dental surgery using place of service code "**11**," "**21**," "**22**", or "**24**," as appropriate. This code does not require Prior Approval for anesthesia claims.

E. A maximum of seventeen (17) units of anesthesia are allowed for a vaginal delivery or Cesarean Section. Refer to Anesthesia Guidelines of the CPT book for procedure codes related to vaginal or Cesarean Section deliveries. Only one (1) anesthesia service is billable for Arkansas Medicaid as the anesthesia for a delivery. The anesthesia service ultimately provided should contain all charges for the anesthesia. No add-on codes are payable.

292.441 Billing for Sterilization on the Same Date of Service as Delivery 10-13-03

When billing for anesthesia for sterilization procedures on the same date of service as a delivery, combine the charges. Medicaid will only allow one base, but the total amount of time involved may be billed. The total amount allowed will not exceed the amount allowed for a total of 17 units. This applies whether the patient is moved to another room or whether there is a lapse of time between the procedures.

292.442 Epidural Therapy 2-1-22

Procedure code should be billed with one (1) unit of service at the time of insertion only. Providers are to bill for daily pain management utilizing procedure code, with one time unit of 15 minutes, with no additional payment to the anesthetist for hospital visits. In cases where the method of anesthesia for surgery is an epidural anesthetic, providers are not allowed to re-bill for the insertion of a catheter for pain management unless there is documentation attached to verify two separate insertions were done. CPT procedure codes describing catheter and/or reservoir/pump implantation are to be used for long-term therapy.

Procedure code must be billed when performed by an anesthesiologist/CRNA.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.443 Medicaid Coverage for Therapeutic Infusions (Excludes Chemotherapy) 2-1-22

Effective for dates of service on and after March 1, 2006, procedure codes are non-payable. These codes have been replaced with procedure codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.444 Guidelines for Anesthesia Values 10-13-03

All anesthesia values are determined by adding a Base Value, which is related to the complexity of the service, plus Modifiers (P1 through P5), plus Time Units.

A Base Value includes the value of all anesthetic services except the time actually spent administering the anesthesia, modifiers and any qualifying circumstance. The Base Value includes usual pre-operative and post-operative visits and the administration of fluids and/or blood incident to the anesthesia. The Base Value for anesthesia when multiple surgical procedures are performed is the Base Value for the procedure with the highest unit value.

If filing electronically, enter only the time points in the "Days or Units" field (Field 24G) in the CMS-1500 claim format. The system will automatically assign the correct number of base points and modifier points.

292.445 Anesthesiologist and CRNA Services 10-13-03

A. If a CRNA is employed by an anesthesiologist group or the anesthesiology group contracts with the CRNA, then the anesthesiologist may bill for the CRNA services.

B. No Medicaid supervision fee is paid to the anesthesiologist/physician for supervising a CRNA.

C. Multiple anesthesia claims for the same dates of service are considered duplicates. The first anesthesia claim received by Arkansas Medicaid will be paid.

292.446 Time Units 2-1-22

Time units will be added to the Base Value and the Anesthesia Modifier for all cases at the rate of 1.0 Unit for each 15 minutes or any fraction thereof. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision. Enter the time units in Field 24G for paper claims. If filing electronically, the value submitted in this field should be the total anesthesia in minutes.

Anesthesia stand-by should be billed as detention time using procedure code**.** One unit equals 30 minutes. A maximum of one unit per date of service may be billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.447 Example of Proper Completion of Claim 11-1-08

The following is a cutaway section of the CMS-1500 claim form demonstrating the proper method of entering the following information:

Line No. 1 - Anesthesia for Procedure
Line No. 2 - Qualifying Circumstance

The anesthesia time must be listed above the procedure code, but on the same detail.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									180 min. = 12 units							
	07	15	07				21		00560	P3	441.3	xxx	xx	12	NPI	105967001
2																105967001
	07	15	07				21		99116	P3	441.3	xxx	xx	1	NPI	

292.450 Assistant Surgery 11-1-17

Assistant surgeon's fees require prior authorization and use of modifiers 80, 81, and 82 billed with the same procedure code billed by the primary physician. Do not use modifier AS. Modifier AS is not utilized by Arkansas Medicaid.

292.451 Co-Surgery 7-1-07

Co-surgeon billing is indicated with modifier 62. Modifier 62 must be used in accordance with CPT guidelines. Operative reports from all physicians performing surgery during the same operative session must be attached to the claim that includes modifier 62.

292.460 Reserved 2-15-15

292.470 Fluoride Varnish Treatment 2-1-22

The American Dental Association (ADA) procedure code is covered by the Arkansas Medicaid Program. This code is payable for beneficiaries under the age of twenty-one (21). Topical fluoride varnish application benefit is covered every six (6) months plus (1) day for beneficiaries under age twenty-one (21).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to Provider Enrollment before the specialty code will be added to their file in the MMIS. After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code D1206, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20). View a CMS-1500 sample form.

292.480 Cataract Surgery 2-1-22

Post-cataract lens implant must be billed using procedure code. This procedure code may be billed electronically or on paper. The lens implant code is billed in conjunction with the cataract surgery and is covered for eligible Medicaid beneficiaries of all ages in the outpatient setting.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.490 Clinical Brachytherapy 2-1-22

The following is clarification regarding Medicaid's policy for hospital admissions, daily visits and discharges in conjunction with clinical brachytherapy. CPT currently states, "Services **77750** through **77799** include admission to the hospital and daily visits." The Medicaid Program does not cover separate payment for hospital admissions or inpatient physician visits when procedure codes are billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.500 Clinic or Group Billing 10-13-03

Multiple providers who wish to have payment made to a group practice or clinic may bill Medicaid on the same claim. If applicable, enter the Arkansas Medicaid Clinic Number in Field 33 after "GRP#." Enter the attending physician number in Field 24K.

292.510 Dialysis 2-1-22

A. Hemodialysis

The following procedure codes must be used by the nephrologist when billing for acute hemodialysis on hospitalized patients. Class I and Class II must have a secondary diagnosis listed to justify the level of care billed.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

These are global codes. Hospital visits are included and must not be billed separately.

B. Peritoneal Dialysis

The following procedure codes must be used when billing for physician inpatient management of peritoneal dialysis. Class I and Class II must have a secondary diagnosis code listed to justify the level of care billed.

These are global codes. Hospital visits are included and must not be billed separately.

C. Outpatient Management of Dialysis

The Arkansas Medicaid Program will reimburse for outpatient management of dialysis under procedure codes.

One day of dialysis management equals one unit of service. A provider may bill one day of outpatient management for each day of the month unless the beneficiary is hospitalized. When billing for an entire month of management, be sure to include the dates of management in the "Date of Service" column. Only one month of management must be reflected per claim line with a maximum of 31 units per month. If a patient is hospitalized, these days must not be included in the monthly charge. These days must be split billed. An example is:

Arkansas Medicaid also covers Iron Dextran for beneficiaries of all ages who receive dialysis due to acute renal failure. Use procedure code when administering in a physician's office.

Procedure codes are payable for eligible Medicaid beneficiaries of all ages who receive dialysis due to acute renal failure (**View ICD Codes.**).

292.520 Evaluations and Management

292.521 Consultations 2-1-22

When billing for office consultations when the place of service is the provider's office (POS: **11**) or inpatient hospital (POS: **21**), use the appropriate CPT procedure codes according to the description of each level of service.

The consultation procedure codes listed below must be used when the place of service is outpatient hospital or emergency room-hospital (POS: **22** or **23**, respectively) or ambulatory surgical center (POS **24**).

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Medicaid does not cover follow-up consultations. A consulting physician assuming care of a patient is providing a primary evaluation and management service and bills Medicaid accordingly within CPT standards.

For information on benefit limits for all consultation (inpatient and outpatient) refer to Section 226.100 of this manual.

292.522 Critical Care 10-13-03

When billing for critical care services, refer to the CPT book for procedure codes and billing information.

292.523 Detention Time 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code must be used by physicians when billing for detention time.

One unit equals 30 minutes. A maximum of 1 unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a physician.

292.524 Follow-Up Visits 7-1-05

Ten (10) days of postoperative care are included in the global surgery fee with the following exceptions:

A. When a modifier **"24"** is attached to the subsequent visit procedure code and the detail diagnosis is unrelated to the surgical procedure performed within the previous 10 days.

NOTE: Use of the "24" modifier must follow national guidelines.

B. When another doctor treating the patient for another condition sees the patient following surgery.

C. When an endoscopy procedure is described as diagnostic.

NOTE: If another procedure is performed and it is not described as diagnostic, the follow-up visits will not be allowed.

D. Intubation endotracheal, emergency procedure.

292.525 Hospital Discharge Day Management 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code**,** hospital discharge day management, may not be billed by providers in conjunction with an initial or subsequent hospital care code, procedures**.** Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

292.526 Initial Visits 10-13-03

Initial visit CPT procedure codes must be used only for the first visit of a new patient. Each subsequent visit requires an established patient code. A distinction is made in CPT procedure codes for new or established patients for office visits, home visits, nursing facility visits and emergency room visits. (See the CPT book.)

Providers are allowed to bill one new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

292.527 Inpatient Hospital Visits 10-13-03

Each attending physician is limited to billing one day of care for inpatient hospital covered days, regardless of the number of hospital visits rendered.

292.528 Nursing Home Visits 10-13-03

The appropriate CPT procedure codes must be used when billing for physician visits in a nursing facility.

292.530 Extracorporeal Shock Wave Lithotripsy (E.S.W.L.) 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Payment for E.S.W.L. is available through the Medicaid Program for the "physician operator" and the "aftercare physician." The physician operating the lithotripter must use CPT procedure code. If a bilateral procedure is done, enter a "2" in the units column. The physician who did not perform the surgery but who referred the patient to the facility for the lithotripsy procedure and will provide "aftercare" services, should bill for the actual services rendered. The anesthesiologist should follow normal billing procedures. Refer to Sections 251.260 and 272.400 of this manual for coverage and reimbursement information.

292.540 Factor VIII, Factor IX and Cryoprecipitate 2-1-22

Anti-hemophiliac Factor VIII is covered by the Arkansas Medicaid Program when administered in the outpatient hospital, physician's office or in the patient's home. The following procedure codes must be used:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Factor VIII [antihemophilic factor (human)], per IU

Factor VIII [antihemophilic factor (porcine)], per IU

Factor VIII [antihemophilic factor (recombinant)], per IU

The provider must bill his/her cost per unit and the number of units administered.

HCPCS procedure code must be used when billing for Factor IX Complex (human). Factor IX Complex (Human) is covered by Medicaid when administered in the physician's office or the patient's home (residence). The provider must bill his/her cost per unit and the number of units administered.

The Arkansas Medicaid Program covers procedure code Cryoprecipitate. This procedure is covered when provided to eligible Medicaid beneficiaries of all ages in the physician's office, outpatient hospital setting or patient's home.

Providers must attach a copy of the manufacturer's invoice to the claim form when billing for Cryoprecipitate.

For the purposes of Factor VIII, Factor IX and Cryoprecipitate coverage, the patient's home is defined as where the patient resides. Institutions, such as a hospital or nursing facility, are not considered a patient's residence.

292.550 Family Planning Services 11-1-10

Sections 292.550 through 292.553 include specific family planning billing protocols. See Sections 221.000 and 243.000 through 243.500 and 251.290 for family planning coverage information.

292.551 Family Planning Services For Beneficiaries 1-1-24

Family planning services are covered for beneficiaries in full coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable**

to some procedures. Laboratory procedure codes covered for family planning are listed in Section 292.552.

A. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, 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 hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist**. **View or print form DMS-615 (Spanish) and the checklist**.

B. The following procedure table explains family planning procedure codes payable to physicians. These codes require modifier FP except for hospital-based physicians. (See Sections D, E and F below for codes payable to hospital-based physicians.)

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations.

**This procedure requires special billing instructions. Refer to Section 292.553.

***Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider.

¤This procedure code is not to be billed with an FP modifier but should follow the anesthesia billing protocol as seen in Sections 272.100, 292.440 through 292.442 and 292.444 through 292.447.

C. The following procedure code table explains the family planning visit services payable to physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

D. The following procedure code table explains the codes that are payable to hospital-based physicians.

*CPT codes represent procedures to treat medical conditions as well as for elective sterilizations; however, these procedure codes are not allowable for Aid Category 69.

**This procedure requires special billing instructions. Refer to Section 292.553.

E. The following procedure code table explains the family planning visit services payable to the hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

F. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
2. If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within an inpatient stay. On the outpatient claim, **see LARC billing combinations for billing codes**. Ensure the applicable NDC code is submitted on the claim.
3. Physician charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. **See LARC billing combinations for billing codes**.
4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.

G. The following procedure code table explains the pathology procedure code payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Family planning laboratory codes are found in **Section 292.552**.

292.552 Family Planning Laboratory Procedure Codes 2-1-22

Family planning services are covered for beneficiaries in full coverage aid categories and the limited coverage Aid Category 61 (PW-PL). For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning, as listed in Section A below. Laboratory codes payable to hospital-based physicians are listed in Section 292.552 (C) below.

A. The following procedure code table explains family planning laboratory procedure codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

*Procedure codes are limited to one unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

¤See points B and C below for information regarding this procedure code.

¤¤When **not** billing for family planning, see Section 292.602.

B. Laboratory codes payable to **non-hospital-based** physicians

The following procedure code table explains laboratory services payable to non-hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to **hospital-based** physicians

The following procedure code table describes the laboratory services payable to hospital-based physicians.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

292.553 Coverage and Billing Protocols Related to Procedure Code 58565 12-18-15

Family planning services are covered for beneficiaries in full coverage aid categories and the limited coverage Aid Category 61(PW-PL). For information regarding additional aid categories, see Section 124.000**. The primary detail diagnosis on the claim must be a family planning diagnosis. Effective for dates of service on or after August 31, 2009, billing protocols have been changed to allow providers to bill and be reimbursed for the portion of service that they provide when this method of sterilization is chosen. Billing may be for the procedure, provision of the device or both.**

A. Billing Protocol for 58565

All providers are to separate their charges when billing for:

1. **Performance of the "procedure"** for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY" (**CPT procedure code 58565**). This service includes all supplies except provision of the device. Claims must be billed on paper with a correct DMS-615 form attached. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**
2. **Provision of the implant "device"** for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—DEVICE ONLY." Claims may be billed electronically or on paper.

   NOTE: Payment of the claim for the "device" will not be made without a paid or pending 58565 "procedure" claim.

B. Professional Claims for 58565

Bill for physicians' claims using the following protocol:

See below the procedure code(s), required modifier(s) and descriptions for ***non-hospital-based*** **physician claims related to procedure code 58565.**

NOTE: The device is only billable when provided in the physician's office place of service.

The following procedure table explains services payable to **non-hospital-based** physicians related to **58565.**

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

Procedure Code	Modifier(s)	Description
58565	FP	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY
58565	FP, U1	Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—DEVICE ONLY

The following procedure code table explains services payable to **hospital-based** physicians related to procedure code **58565.**

Procedure Code	Modifier(s)	Description
58565		Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY

All sterilization coverage and billing requirements must be met in order to be reimbursed for these services.

C. Procedures Relating to **58565** "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants"

1. **Performance of the "procedure"** for: "Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants—PROCEDURE ONLY" (**CPT procedure code 58565**). This service includes all supplies except provision of the device. Claims must be billed on paper with a correct DMS-615 attached**. View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**

   a. Professional claims for conscious sedation (procedure codes 99144 and 99145) may be covered as a family planning service only when administered in conjunction with the **58565** "procedure."

   b. When **99144** and **99145** are billed for family planning, there must be a paid or pending professional claim for the **58565** "procedure" when billing for the same date of service.

   c. To file claims for professional services (non-hospital-based physician), use modifier FP. Whether billing electronically or on paper, the primary detail diagnosis for each procedure *must* be a family planning diagnosis code.

   d. Claims for professional services that were provided in an outpatient hospital clinic should not include modifiers. Whether billing electronically or on paper, the primary detail diagnosis for each procedure *must* be a family planning diagnosis code.

2. Procedure codes **58340, 58345, 72190, 74740** and **74742** are payable as **family planning services** only when provided within six months of the **58565 "procedure"** date of service. For the post-**58565 "procedure" services** limit: 6 months is 180 days, with the count beginning the day after the procedure.

   NOTE: Payment of any of these procedure codes requires that 58565 is already a *paid* or *pending* claim.

   a. Professional claims (**non-hospital-based** physician) for procedure codes **58340** and **58345** must be filed with modifier **FP**.

   The following instructions apply when procedures **58340** and **58345** are performed in an outpatient clinic associated with a hospital:

   Claims for professional services for **58340** or **58345,** when provided in an outpatient clinic associated with a hospital, are to be filed with no modifiers. Whether billing electronically or on paper, a family planning diagnosis code *must* be listed as primary on the claim detail.

   Professional claims (**non-hospital-based** physician) for procedures **72190**, **74740** and **74742** must be filed with modifier **FP**. Whether billing electronically or on paper, a family planning diagnosis code *must* be listed as primary on the claim detail.

   b. When these radiology procedures are performed as family planning services in an outpatient hospital or an outpatient hospital clinic by a **hospital-based**

physician**,** bill Medicaid in accordance with the following instructions:

Claims for the professional component of procedure codes **72190, 74740** and **74742** are to be billed with no modifiers. Whether billing electronically or on paper, a family planning diagnosis code *must* be listed as primary on each detail.

3. Procedure codes **J1050, 11976** and **58301** are currently payable family planning services. These procedures are covered up to six months, as necessary for follow-up services to procedure **58565.** When provided for post-**58565** follow-up care, billing protocol for **J1050**, **11976** and **58301** is unchanged for all providers.

   All visits related to post-**58565** services during the six months following the procedure are included in the allowable fee for the 58565 "procedure."

292.560 Genetic Services 2-1-22

The Arkansas Medicaid Program covers the following procedure codes regarding genetic services.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Documentation

In addition to the medical records physicians are required to keep as detailed in Section 202.200 of this manual, the beneficiary's medical record must verify the physician providing genetic services is a board-certified maternal fetal medicine physician as required by Arkansas Medicaid genetic policy.

B. Prenatal Diagnosis Counseling

Prenatal Diagnosis Counseling must be performed by a maternal fetal medicine physician or a staff member under his or her direct supervision. This service includes, but is not limited to:

1. Family, medical, pregnancy history
2. Psychosocial assessment and counseling of couple regarding genetic testing and disorder
3. Diagnosis, prognosis, available options, pregnancy management are explained to the couple.

C. Services Not Performed by a Physician

When procedure code **(must be billed on paper)** is provided and the services are not performed by a physician, the provider must have written policies with a physician who assumes the responsibility for the provision of the services rendered and agrees:

1. To be immediately available for consultation to the staff performing the services,
2. To ensure that the clinic staff has appropriate training and adequate skills for performing the procedures for which they are responsible and
3. To periodically review the staff's level of performance in administering these procedures.

The physician must be physically present (under the same roof) at all times during the service delivery.

292.561 Hysteroscopy for Foreign Body Removal 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code requires paper billing and clinical documentation for justification.

292.570 Reserved 9-15-12

292.575 Child Health Services (EPSDT) Screenings and Sick Visits 11-1-17

Screenings performed on the same date of service as an office visit for treatment of an acute or chronic condition may be billed as a periodic Child Health Services (EPSDT) screening, electronically or on paper using the CMS-1500 claim form. Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening/ARKids First B preventative screening. Please resubmit any denied claims with the required modifiers along with Modifier 25 in the first modifier position within the required 365-day filing limit.

Effective for dates of service on and after May 1, 2006, a Child Health Services (EPSDT) screening performed during an office visit for treatment of an acute or chronic condition may be billed as a separate visit for the same date of service using a CPT evaluation and management procedure code. The visit must be billed electronically, or on paper using a separate CMS-1500 form. **View a CMS-1500 sample form.**

See Sections 241.000 – 243.310 of the EPSDT manual for specific EPSDT billing instructions.

292.580 Hysterectomies 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Physicians may use nationally recognized procedure code when billing for a total hysterectomy procedure when the diagnosis is malignant neoplasm or severe dysplasia. See Section 251.280 for additional coverage requirement.

Procedure code does not require prior authorization (PA). All hysterectomies require paper billing using claim form CMS-1500. Form DMS-2606 must be properly signed and attached to the claim form.

Procedure code is covered for emergency hysterectomy **immediately** following C-section. It requires no PA but does require form DMS-2606 and an operative report/discharge summary to confirm the emergency status.

292.590 Reserved 2-15-15

292.591 Molecular Pathology 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Molecular Pathology procedure codes, including Healthcare Common Procedural Coding System Level II (HCPCS) procedure code requires prior authorization (PA). Providers must receive prior authorization before a claim for molecular pathology is filed for payment. Providers may request the PA from DHS or its designated vendor before or after the procedure is performed as long as it is acquired in time to receive approval and file a clean claim within the

365-day filing deadline. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.**

Molecular Pathology PA requests must be submitted by the performing provider with submission of a completed Arkansas Medicaid Request for Molecular Pathology Laboratory services (**Form DMS-841**) and all pertinent clinical documentation needed to justify the procedure. Reconsideration of a denied request is allowed if new or additional information is received within thirty (30) days of the initial denial. A copy of the **DMS-841** is located in Section V of this provider manual. **View or print form DMS-841**. Do not complete DMS-841 unless you are submitting a Molecular Pathology Prior Authorization request. **Molecular Pathology procedure codes must be submitted on a red line CMS-1500 claim form with the Prior Authorization number listed on the claim form and the itemized invoice attached which supports the charges for the test billed.**

Use Healthcare Common Procedural Coding System Level II (HCPCS) procedure code for coding the Interpretation and Report of 2013 Molecular Pathology codes that allow separate Interpretation and Report. The prior authorization request for must be submitted with the Arkansas Medicaid Request for Molecular Pathology Laboratory Services (Form DMS-841). Prior authorization for must be obtained at the same time as the prior authorization for the CPT Molecular Pathology code. The prior authorization request for must include the CPT Molecular Pathology procedure code for which the Interpretation and Report is to be provided. must be billed on a red line CMS-1500 paper claim form with CPT Molecular Pathology code(s) specified for which the Interpretation and Report was performed. The claim form should list the prior authorization number. The invoice must be attached that reflects the cost to the provider for performing the interpretation and report of the test.

See Section 262.000 for additional information on Molecular Pathology procedure codes.

292.592 Reserved 4-1-14

292.593 Reserved 4-1-14

292.594 Reserved 4-1-14

292.595 Special Pharmacy, Therapeutics and Radiopharmaceutical Therapy and Treatments 9-15-12

A. Special pharmacy and therapeutic agents are covered with prior approval from the Division of Medical Services Medical Director for Clinical Affairs.

1. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.
2. Each claim must reflect, in the description of service field, the number in the treatment series of each administration for which you are billing Medicaid.
3. No prior authorization number is issued; therefore, a copy of the Medical Director for Clinical Affairs' approval letter must be attached to each claim filed.

Refer to Section 244.100 for coverage information and instructions for requesting prior approval.

B. Radiopharmaceutical therapy is covered with prior approval from the Medical Director for Clinical Affairs for the Division of Medical Services.

1. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.
2. A copy of the Medical Director for Clinical Affairs' approval letter and a copy of the invoice for the monoclonal antibody used must be attached to the claim form.

Refer to Section 244.200 for coverage information and instructions for requesting prior approval.

292.599 New Pharmacy Therapeutics 9-15-12

New pharmacy and therapeutic agents are covered with prior approval from the Division of Medical Services Medical Director for Clinical Affairs.

A. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.

B. Each claim must reflect, in the description of service field, the number in the treatment series of each administration for which you are billing Medicaid.

C. No prior authorization number is issued; therefore, a copy of the Medical Director for Clinical Affairs' approval letter must be attached to each claim filed.

Refer to Section 244.100 for coverage information and instructions for requesting prior approval.

292.600 Laboratory and X-Ray Services 2-1-22

Only laboratory and X-ray services carried out in the physician's office or under his/her direct supervision may be billed by the physician to the Medicaid Program. Laboratory and X-ray services ordered by the physician but carried out in an outside facility must be billed directly to Medicaid by the outside facility. Physician will be reimbursed for collection fee only.

Medicaid regulations regarding collection, handling and/or conveyance of specimens are:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including: (1) drawing a blood sample through venipuncture (e.g., inserting into a vein a needle with syringe or vacutainer to draw the specimen); or, (2) collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

NOTE: The P codes listed are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, no collection fee may be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

292.601 Organ or Disease Oriented Panels 10-13-03

Laboratory tests done as groups and combinations (panels) must be billed using panel procedure codes. Refer to the Pathology and Laboratory Section of the CPT book for specific information regarding codes for the panels. When panels are performed, billing by individual test procedure is not allowable.

292.602 Special Billing Requirements for Lab and X-Ray Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.603 Billing Protocol for Computed Tomographic Colonography (CT) 2-1-22

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography codes are covered with a primary ICD diagnosis of (**View ICD codes.)**
2. CT colonography is billable electronically or on paper claims.

See Section 225.200 for coverage protocol

292.610 Magnetic Resonance Imaging (MRI) 10-1-15

The appropriate CPT procedure codes must be used when billing for magnetic resonance imaging (MRI). Medical necessity for each MRI must be documented in the beneficiary's medical record. The following diagnosis code (**View ICD codes.**) is not an acceptable diagnosis code on claims submitted for these procedures.

292.620 Office Medical Supplies - Beneficiaries Under Age 21 2-1-22

For beneficiaries under age 21, procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. Procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Procedure code is limited to beneficiaries under age 21. Use the EP modifier for ARKids A.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.630 Medicare

292.631 Services Prior to Medicare Entitlement 10-13-03

If Medicare denies a service with the explanation "Services Prior to Medicare Entitlement" submit the Medicaid claim electronically to the Arkansas Medicaid fiscal agent. If the Arkansas Medicaid fiscal agent rejects or denies the claim because this beneficiary has Medicaid, submit a hard copy claim to the Inquiry Unit. **View or print the Inquiry Unit contact information.** A copy of the Medicare denial should be attached to the claim.

A claim inquiry form must accompany these claims in order that they may receive special handling.

292.632 Services Not Medicare Approved 10-13-03

Services that are not Medicare-approved are usually not payable by Medicaid.

292.640 Multiple Surgery 2-1-06

If multiple surgical procedures are done on the same day of service, whether in the same operative session or not, each procedure should be listed in field 24.D on **one** claim form, including all appropriate modifiers. For paper claims, attach all necessary documentation to the claim. Filing all services that are performed on the same date of service on **one** claim is necessary to expedite correct payment of each procedure.

292.650 NeuroCybernetic Prosthesis 2-1-22

Arkansas Medicaid requires prior authorization for the following procedures related to the implantation, revision and removal of the NeuroCybernetic Prosthesis (NCP®), a vagus nerve stimulator (VNS):

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.660 Newborn Care 2-1-22

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician can refer interested individuals to the Department of Human Services through the Hospital/Physician Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

Newborn Care Services (Initial Screening)

These procedure codes represent the initial newborn screening. This screening includes the physical exam of the baby and the conference(s) with newborn's parent(s) and is considered to be the initial newborn care/screen. Payment of these codes is considered a global rate and subsequent visits may not be billed in addition to codes.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Note the descriptions, modifiers and required diagnosis range. For all providers, the newborn care procedure codes require a modifier or modifiers and a primary detail diagnosis of (**View ICD Codes.**).

A. Physician Billing Instructions for Newborn Care

For ARKids First-A (EPSDT): Requires a CMS-1500 claim form; may be billed electronically or on paper.

See Sections 241.000 – 242.400 of the EPSDT manual for specific EPSDT billing instructions.

For ARKids First-B: Requires a CMS-1500 claim form; may be billed electronically or on paper.

View or print Child Health Services contact information.

For illness care, e.g., neonatal jaundice, use procedure codes. Do **not** bill in addition to these codes.

When billing for critical care services, refer to the CPT book for procedure codes and billing information.

For newborn resuscitation, use procedure code.

292.670 Obstetrical Care 10-13-03

There are two methods of billing for obstetrical care.

292.671 Method 1 - "Global" or "All-Inclusive" Rate 2-1-22

The global method of billing should be used when one (1) or more physicians in a group see the patient for a prenatal visit and one (1) of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the beneficiary's physician visit benefit limit if the global method is billed.

A. One (1) charge for total obstetrical care is billed. The single charge includes the following:

1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to the pregnancy.
2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.
3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.
4. Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

B. The global method must be used when the following conditions exist:

1. At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.
2. The patient was continuously Medicaid eligible for two (2) months or more months before delivery and on the delivery date.

If either of the two (2) conditions is not met, the services will be denied, stating either "monthly billing required" or "beneficiary ineligible for service dates".

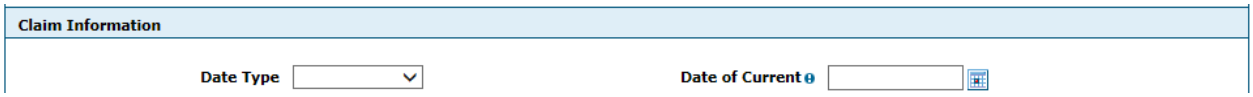
C. The correct codes for billing Medicaid for global obstetric care are as follows.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim. The delivery date is the date that is to be in the From and To Date of Service billed on the line with the above codes. The first date of antepartum care is to be billed in the "Initial Treatment Date" field.

For the CMS 1500 claim form, this is field 15 – Other Date Field. Qualifier 454 is required.

For the Provider Portal, the Date Type is “Initial Treatment Date” and the Date of Current is the first date of antepartum care.



If these two (2) dates are not entered and are not at least two (2) months apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.

292.672 Method 2 - “Itemized Billing” 2-1-22

Use this method only when either of the following conditions exists:

A. Less than two months of antepartum care was provided

B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient’s annual physician benefit limit. Date-of-service spans shall not include any dates for which the patient was ineligible for Medicaid.

Bill Medicaid for the delivery and postpartum care with the applicable procedure code from the following table:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

If Method 2 is used to bill for OB services, providers must ensure that the services are billed within the 365-day filing deadline.

If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes must be billed for vaginal delivery and procedure codes must be billed for cesarean section. Procedure codes shall not be billed in addition to procedure codes. These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.

Laboratory and X-ray services may be billed separately using the appropriate CPT codes, if this is the physician’s standard office practice for billing OB patients. If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are totally dependent on the referring physician for diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code consists of four components: Complete Blood Count, VDRL, Rubella and blood typing and RH. If the ASO titer is performed, the test must be billed separately using the individual code.

Only a collection may be filled for laboratory procedures, if a blood specimen is sent to an outside laboratory, only a collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.673 Fetal Non-Stress Test and Ultrasound 2-1-22

The Arkansas Medicaid Program covers the fetal non-stress test and the ultrasound when performed in conjunction with maternity care.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Arkansas Medicaid imposes a benefit limit of two medically necessary fetal non-stress test procedures per pregnancy. Fetal ultrasound is limited to two per pregnancy. If it is necessary to exceed these limits, the physician must request benefit extensions, when applicable, in accordance with benefit extension request instructions in this provider manual.

292.674 External Fetal Monitoring 2-1-22

Procedure code must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code **"11.** Physicians may bill for one unit per day of external fetal monitoring. Physicians may bill for external fetal monitoring in addition to a global obstetric fee. When itemizing obstetric visits, physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.675 Obstetrical Care Without Delivery 2-1-22

A. Obstetrical care without delivery may be billed using procedure code, modifier **UA**, when 1 – 3 visits are provided and with no modifiers when 4 – 6 six visits are provided. Procedure code with no modifiers is payable for 7 or more visits.

   View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

B. These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes are not counted against the patient's annual physician visit benefit limit. Reimbursement for each visit includes routine sugar and protein analysis. Other lab tests may be billed separately within 12 months of the date of service.

C. Providers must enter the dates of service in the CMS-1500 claim format and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.

   View a CMS-1500 sample form.

   For example: An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. The Arkansas Medicaid fiscal agent must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: with modifier **UA** when 1 – 3 visits are provided, with no modifiers when 4 – 6 visits are provided and procedure code when 7 or more visits are provided.

292.676 Risk Management for Pregnancy 2-1-22

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

For early discharge home visits, use one of the applicable CPT procedure codes.

292.680 Outpatient Hospital Services

292.681 Emergency Services 10-13-03

The appropriate CPT codes should be used when billing for physician visits in an outpatient hospital setting for emergency services.

292.682 Non-Emergency Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code, modifier **U1**, should be billed for a non-emergency physician visit in the emergency department. Procedure code, modifier **U1**, requires PCP referral. This procedure code is subject to the non-emergency outpatient hospital benefit limit of 12 visits per state fiscal year (SFY).

Physicians must use procedure code, modifier **U2**, **Physician Outpatient Clinic Services** for outpatient hospital visits. This service requires a PCP referral. Procedure codes, modifier **U1**, and, modifier **U2**, are subject to the benefit limit of 12 visits per SFY for non-emergency professional visits to an outpatient hospital for patients age 21 and over.

To reimburse emergency department physicians for determining emergent or non-emergent patient status, Medicaid established a physician assessment fee. Procedure code, **Physician Assessment in Outpatient Hospital** is payable for beneficiaries enrolled with a PCP. The procedure code does not require PCP referral. The procedure code does not count against the beneficiary's benefit limits, but the beneficiary must be enrolled with a PCP. It is for use when the beneficiary is not admitted for inpatient or outpatient treatment.

292.683 Therapy and Treatment 10-13-03

The professional services related to all covered hospital therapy and treatment will be reimbursed according to Physician Fee Schedule Rates for the appropriate CPT procedure code.

292.684 Outpatient Hospital Surgical Procedures 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The CPT surgical codes for the covered procedure should be used for billing. Reimbursement for the procedure will be based on the Medicaid Physician Fee Schedule. When billing a miscellaneous surgical code, attach an operative report.

292.690 Pelvic Examinations, Prostatic Massages, Removal of Sutures, Etc. 2-1-22

These services are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.700 Physical and Speech-Language Therapy Services Billing 1-1-21

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Speech-language therapy and physical therapy evaluations are payable to the physician. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, and Speech-Language Therapy Services Manual. The procedure codes at the following link must be used when filing claims for physician provided therapy services: **View or print the procedure codes for therapy services**. See Glossary - Section IV - for definitions of “group” and “individual” as they relate to therapy services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech-language therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

Refer to Section 227.000 of this manual for more information on therapy benefits.

292.710 Prior Authorization Control Number 10-13-03

When billing for procedures that have been prior authorized, be sure to enter the 10-digit prior authorization control number. See Section 260.000 of this manual for additional information.

292.720 Billing for Professional Component of Services Performed in a Hospital 10-13-03

A. Radiology

The attending physician is not allowed payment for the professional component on X-rays performed by the hospital and interpreted by the radiologist contracted by the hospital to read all X-ray examinations. This policy also applies if the attending physician must read the X-ray because the radiologist is not present to view the X-ray at the time of service. In these situations, the radiologist will be paid due to his/her expertise and liability involved in performing this service and the JCAH requirement that the radiologist view all films performed in the hospital.

B. Arterial Blood Gases

The attending physician is not allowed payment for the professional component of arterial blood gases when the hospital performs the technical component of this service. Because this service is a routine part of the management of a critically ill patient, blood gases interpretation should be included in an appropriate level of service for hospital visits by the physician. This policy is confirmed according to the description of the higher level of service in the CPT procedure-coding book. Billing individually for the professional component is considered a fragmentation of service and payment for this component will be denied.

C. Other Procedures

The attending physician is allowed payment for interpretation of pulmonary function tests and other such procedures if the hospital does not provide for this service. If the hospital

does contract with a physician to provide this service, payment will be denied to the attending physician.

D. Electrocardiograms

In keeping with Medicare's policy regarding coverage of electrocardiogram interpretations, payment is allowed to the attending physician for electrocardiogram interpretation performed at the hospital. This is allowed as a basic service even if additional services such as Computer Telemed Service and associated over reads are performed through the hospital. This policy is based on the fact that physicians usually interpret their own EKGs unless they refer to a specialist to perform this service. In cases involving the attending physician interpreting the electrocardiogram and referring the case to a cardiologist, the attending physician is allowed payment for the interpretation. The cardiologist will be paid for his/her interpretation of the electrocardiogram by including this service in the consultation fee.

292.730 Professional and Technical Components 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Covered laboratory and radiology procedure codes in code range as well as covered services listed in the Medicine section of CPT and HCPCS procedure codes manuals that require the use of a machine may be billed electronically or on paper. Codes in this range without an applicable modifier signify a complete procedure.

Applicable modifiers are required in Field 24D in addition to the procedure code. Modifier **TC** must be used for the technical component and modifier **26** must be used for the professional component.

292.740 Counseling Services 1-1-23

The **counseling procedures** covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide them.

Counseling Services must be provided by a physician or qualified performing provider in the physician's office or the outpatient hospital. Counseling codes may not be billed in conjunction with an inpatient hospital visit, or inpatient psychiatric facility visit and may not be billed when services are performed as Medicaid Behavioral Health Counseling Services at another enrolled Arkansas Medicaid provider type site. Only one (1) counseling visit per day is allowed in the physician's office, the outpatient hospital, or nursing home. Counseling Services provided and billed by a physician's office are defined in the Arkansas Medicaid **Counseling Services provider manual**. The rules set forth in the Counseling Services manual will apply with the exception of the place of service codes. Place of service will be limited to the following place of service codes: Place of Service Code 22 Outpatient Hospital, 11 Doctor's Office and 12 Patient's Home. Any additional services provided by a psychiatrist enrolled in the physician's program will count against the sixteen (16) visits per State Fiscal Year physician benefit limit. Record Review is not covered.

292.741 Behavioral Health Screen 1-1-23

A physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening

billed under the minor's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling screening limit. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source.

292.742 Family/Group Psychotherapy 2-1-22

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family/group psychotherapy:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure code is payable only when the patient is present during the treatment. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

292.750 Radiation Therapy 7-1-07

Refer to the Radiology section of the CPT coding book for appropriate CPT procedure codes.

292.760 Rural Health Clinic (RHC) Non-Core Services 2-1-22

Physician groups whose individual practitioners are contracting with a rural health clinic are limited to billing Medicaid for Rural Health Clinic (RHC) non-core services. These providers may bill the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

RHC NON-CORE SERVICES	
Outpatient Hospital Visits	**Inpatient Hospital Visits**
Non-emergency: modifier U1	
Emergency:	
Electrocardiograms and Echocardiography Technical component only Modifier TC	**Radiology Technical component only Modifier TC**
Surgery, Outpatient and Inpatient	
All payable CPT procedure codes within range	

NOTE: Inpatient and outpatient hospital services are RHC non-core services only if the physician's contract with the RHC does not state that the physician will be compensated by the RHC for those services. Interpretation of X-rays and diagnostic machine tests in the inpatient or outpatient hospital is a non-core service when the visit itself is a non-core service. Home visits, nursing facility visits or other off-site visits are RHC encounters if the physician's agreement with the RHC requires that he or she provide the services and seek compensation from the RHC. Any of these off-site services is payable separately (through the Physician Program) from the RHC encounter fee if it is not a part of the physician's contract with the RHC.

See Sections 201.120 and 246.000 of this manual for additional information.

292.770 Sexual Abuse Examination for Beneficiaries 0 - 20 Years 2-1-22

The procedure code **for Sexual Abuse Examination** listed in the table below is payable to physicians when provided in the physician's office or in a hospital outpatient department, emergency or non-emergency, with National Place of Service: **code "11", "23" or "22"**. This procedure is exempt from the PCP referral requirement and is covered for beneficiaries 0 - 20 years.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.780 Locum Tenens and Substitute Physician Policy 7-1-13

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements to adhere to **locum tenens physician** and **substitute physician** billing and coverage policies and procedures.

A. Description of Service:

Locum tenens and substitute physicians are terms used to describe the relationship of a physician who is acting as a fill-in for a beneficiary's regular physician. The regular physician may be the beneficiary's primary care physician (PCP) or primary care provider. The regular physician could also be a specialist the beneficiary sees regularly for a chronic condition or a specific problem. A locum tenens or substitute physician must be the same discipline as the regular physician. Documentation of the locum tenens arrangement must include the services provided, the date the services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge and the beneficiary involved.

B. Substitute Physicians:

A substitute physician is a physician who is asked by the regular physician to see a beneficiary in a reciprocal arrangement when the regular physician is unavailable to see the beneficiary. In the substitute physician arrangement, the regular physician reciprocates the substitute physician by paying the substitute the amount received for the service rendered or by serving in the same capacity in return. For this provision to occur, both the regular and the substitute physician must be enrolled in Arkansas Medicaid.

The following billing protocol must be utilized for substitute physician circumstances:

1. The regular physician's office submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute physician.
3. The substitute physician arrangement should not exceed 14 consecutive days. The substitute physician arrangement does not apply to substitution for physicians in the same medical group with claims submitted in the name of the medical group. (For situations in which one group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Physicians:

A locum tenens arrangement is made when the regular physician must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. The locum tenens physician usually has no practice of his or her own and moves from area to area as needed. The physician is usually paid a fixed amount per diem with the status of an independent contractor, not an employee. The locum tenens physician must meet all state, hospital and other institutional credentialing requirements. The locum tenens physician is required to be enrolled in Arkansas Medicaid.

Documentation of the locum tenens arrangement must include the services provided by the locum tenens and when those services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge and the beneficiary involved.

The following billing protocol must be utilized for locum tenens physician circumstances:

1. The regular physician's office submits their claims for locum tenens services using the regular physician's provider identification number.
2. Modifier Q6 is placed in the indicator 24D of the CMS-1500 claim form to indicate services were provided by a locum tenens physician. The payment amount is the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
3. Locum tenens arrangements should not exceed 60 days. If a physician is away more than 60 days, additional locum tenens can be used to fill in for different 60-day periods. This means that various physicians would be required to fill in for different 60-day time periods. Locum tenens is not designed to fill physician vacancies within a practice.

Exception: In accordance with Public Law 110-173, the exception to the 60-day limit on substitute physician billing occurs when a physician is ordered to active military duty in the Armed Forces.

The above billing requirements apply to all substitute physician services including Primary Care Case Management (PCCM) services.

See the table below which compares the requirements for substitute and locum tenens physicians according to Arkansas Medicaid Policy.

REQUIREMENT	SUBSTITUTE PHYSICIAN	LOCUM TENENS PHYSICIAN
Must be enrolled as an Arkansas Medicaid Provider	Yes	Yes
May be enrolled by the same group as the regular physician	No	No
Claims are submitted by the regular physician's office and that office receives payment	Yes	Yes
Modifier required to identify arrangement	Yes, Q5	Yes, Q6
May use the regular physician's certification code for PCP authorization	Yes	Yes
Maximum time frame allowed	14 days	60 days

292.790 Surgical Procedures with Certain Diagnosis Ranges 2-1-22

The following procedure codes are payable by the Arkansas Medicaid Program only if the diagnosis is in the range listed below:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.801 Cochlear Implant and External Sound Processor Billing Protocol 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Procedure code - Cochlear device implantation, with or without mastoidectomy - may be billed only by the physician performing the surgical procedure. When the cochlear device is provided by the physician, the physician may bill procedure code for the cochlear device using **EP** modifier. Paper claims require a modifier **EP** for the device. Procedure code require prior authorization. The physician must attach a copy of the invoice to the CMS-1500 claim form. If the cochlear device is provided by the hospital, the physician may not bill for the device. Refer to Section 251.230 of this manual for coverage information.

Procedures are covered for beneficiaries under age 21 and must be billed with modifier **EP**.

The following procedure codes must be prior authorized. (See Section 261.120 for Prior Authorization requirements and Section 251.230 for coverage policy). Providers should use the following procedure codes when requesting prior authorization for replacement parts for cochlear implant devices. Applicable manufacturer warranty options must be exhausted before coverage is considered. Most warranties include one replacement for a stolen, lost or damaged piece of equipment free-of-charge by the manufacturer.

Some cochlear implant parts have previously been covered services under an unlisted procedure code.

The table below contains new and existing HCPCS procedure codes of FM system for use with a cochlear implant and replacement cochlear implant parts.

Please note: Coverage and billing requirements to the physician provider for cochlear device implantation is unchanged. (See Section 251.230 for coverage requirements.)

Billing and Reimbursement Protocol for FM system and replacement cochlear implant parts:

Procedure codes will be billable electronically or on paper. Claims with procedures codes requiring paper billing must be submitted with a manufacturer's invoice attached that demonstrates the specific cost per item. The invoice must clearly indicate the specific item(s) supplied to the beneficiary for whom the claim is billed. May be submitted electronically or on a paper claim form. Provider charges for an FM system that is meant to be used with a cochlear implant should reflect the retail price. Reimbursement of an FM system to be used with a cochlear implant will be at 68 percent of the retail price.

* Indicates requirement of paper billing with manufacturer invoice attached.

292.810 Reserved

292.811 Reserved 8-1-18

292.812 Reserved 8-1-18

292.813 Reserved 8-1-18

292.820 Organ Transplant Billing 3-15-05

A. All associated claims for a transplant evaluation (e.g., physician, lab and X-ray, dental, etc.) must be forwarded to the Claims Department. **View or print Claims Department contact information.**

B. All claims associated with a transplant procedure must be submitted to the Division of Medical Services, Utilization Review (UR) Section. **View or print Utilization Review contact information.** A copy of any third-party payer Explanation of Benefits must be attached to the claim when applicable.

292.821 Billing for Corneal Transplants 2-1-22

The following CPT procedure codes are payable for corneal transplants with prior approval:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Medicaid will reimburse the physician for the acquisition and preservation of the cornea. Medicaid will not reimburse for the transportation of the cornea. HCPCS procedure code must be used when billing for the acquisition and preservation of the cornea. This code must be billed in conjunction with the transplant surgery. An itemized statement for the acquisition and preservation of the cornea must accompany the CMS-1500 claim form. **View a CMS-1500 sample form.**

292.822 Billing for Renal (Kidney) Transplants 2-1-22

A. The following CPT procedure codes are payable for renal transplants with prior approval:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is non-payable.

1. A separate claim must be filed for the donor. If the donor is not Medicaid eligible, the claim should be filed under the Medicaid beneficiary's name and Medicaid ID number. Diagnosis code (**View ICD Codes.**) (Donors, kidney) must be used for the renal donor and diagnosis code (**View ICD Codes.**) (Other specified general medical examination - examination of potential donor of organ or tissue) must be used for the tissue typing of the donor.
2. If the donor is a Medicaid beneficiary, the claim must be filed utilizing the donor's Medicaid ID number. However, the diagnosis codes listed above must be used.

B. HCPCS procedure code, modifier **UA**, must be used by providers billing for the transportation and preservation of the cadaver kidney. The physician must bill HCPCS procedure code, modifier **UA**, on the claim in conjunction with the transplant surgery. An itemized statement for the transportation and preservation of the kidney must accompany form CMS-1500. **View a CMS-1500 sample form.**

292.823 Billing for Pancreas/Kidney Transplants - Under Age 21 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

The appropriate CPT procedure code should be used when billing for pancreas/kidney transplantation for individuals under age 21 in the Child Health Services (EPSDT) Program. These procedure codes include. Procedure codes for allograft preparation are.

Pancreas/kidney transplantation procedure codes require prior approval. The appropriate code(s) may be billed in conjunction when performing the pancreas/kidney transplant procedure. This surgery will be treated as a multiple surgery and will be reimbursed accordingly.

292.824 Billing for Bone Marrow Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. CPT procedure codes are payable, with prior approval, for a bone marrow transplant. See Section 261.220 of this manual for prior approval information.

B. Harvesting procedure codes do not require prior approval and must be used when billing for the donor.

C. All claims associated with a bone marrow transplant must be filed for payment within 60 calendar days from the discharge date of the inpatient stay for the transplant procedure.

D. CPT procedure code requires an ICD diagnosis code of (**View ICD Codes.**).

1. No claims will be considered for payment after the 60 calendar days have elapsed.
2. If an HIPAA Explanation of Benefits (HEOB) is received from a third-party payer after the 60 calendar days have elapsed, you must forward a copy of the HEOB to the UR Transplant Coordinator.

292.825 Billing for Heart Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is payable for a heart transplant. This code requires prior approval.

292.826 Billing for Liver Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

CPT procedure code is payable for a liver transplant. This code requires prior approval.

292.827 Billing for Liver/Bowel Transplants 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Liver/bowel transplant procedure codes require prior approval.

B. Procedure code is to be used for the liver.

C. Procedure codes are to be used for the intestine, as applicable.

292.828 Billing for Lung Transplants 2-1-22

Arkansas Medicaid covers lung transplants (single or double) for beneficiaries of all ages, if deemed medically necessary and prior approved. Use the following procedure codes:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.829 Reserved 4-1-14

292.830 General Information for Transplants 3-15-05

A. Providers should not submit charges to Medicaid for payment prior to Medicaid eligibility being established for the patient. Medicaid eligibility is determined by the local Human Services office in the county in which the applicant resides.

B. Refer to Sections 251.300 through 251.309 of this manual for coverage information on transplants and Section 261.243 for prior authorization instructions.

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.

292.832 Claim Filing for Living Organ Donors 10-1-15

A. A separate claim must be filed for a living donor (related or unrelated).

1. Use diagnosis code (**View ICD Codes.**) for the tissue typing claims.
2. When filing claims for bone marrow donors, kidney donors or donors of partial liver, use the following diagnosis codes (**View ICD Codes.**), respectively.

B. If the donor is not a Medicaid beneficiary, the claim must be filed under the Medicaid beneficiary's name and ID number.

C. If the donor is a Medicaid beneficiary, the claims must be filed using the donor's name and Medicaid ID number.

292.840 Vascular Embolization and Occlusion 2-1-22

The following procedure codes require paper billing and documentation attached that describes the procedure code and supports medical necessity:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

292.850 Blood or Blood Components for Transfusions 2-1-22

The Arkansas Medicaid Program will reimburse for blood or blood components used for transfusions in the physician's office. CPT procedure code should be used for the administration fee. This includes all supplies used to perform the transfusion. The blood or blood components supplied by the physician may be billed using CPT procedure code.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A copy of the invoice must be attached to the claim form with the amount that was charged for the blood product circled. The number of units provided to the Medicaid eligible patient must be indicated on the invoice. Any laboratory procedures performed may be billed using the appropriate CPT procedure codes.

292.860 Hyperbaric Oxygen Therapy (HBOT) Procedures 2-1-22

Physicians may be reimbursed for attendance and supervision of hyperbaric oxygen therapy (HBOT). Physicians billing for the physician component of "Physician attendance and supervision of hyperbaric oxygen therapy" **may bill for only one unit of service per day.** The physician's charge for each service date must include all his or her hyperbaric oxygen therapy charges, regardless of how many treatment sessions per day are administered.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

A. Physicians may bill for surgery and professional components of anatomical lab procedures, X-rays and machine tests in addition to.

B. Physicians may file paper or electronic claims for with the prior authorization number placed on the claim in the proper field. If multiple prior authorizations are required, enter the prior authorization number that corresponds to the date of service billed.

NOTE: Refer to Section 258.000 of this manual for coverage policy, diagnosis requirements and treatment schedules.

292.870 Reserved 4-1-14

292.880 Enterra Therapy for Gastroparesis 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

When filing claims for Enterra therapy for treatment of gastroparesis, use procedure code for implantation of gastric electrical stimulation and for implantation of peripheral neurostimulator electrodes. A prior authorization number is required on the claim.

Procedure code must be used when filing claims for revision or removal of the peripheral neurostimulator. This procedure does not require prior authorization but the claim must be filed on paper with operative report attached.

292.890 Gastrointestinal Tract Imaging with Endoscopy Capsule 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Gastrointestinal Tract Imaging with Endoscopy Capsule, billed as, is payable for all ages and must be billed with the primary detail diagnosis of (**View ICD Codes.**).

This procedure code should be billed with no modifiers when performed in the physician's office place of service.

Modifier 26 must additionally be used to indicate billing for the professional component when performed in the inpatient, outpatient hospital, or ambulatory surgical center place of service.

CPT code is payable on electronic and paper claims. For coverage policy, see Section 256.000.

292.900 Tobacco Cessation Counseling Services 2-1-22

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **designated Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**

⁂**(…)** This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

* Exempt from PCP referral.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent/legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under the age of eighteen (18), and the parent/legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count toward the four (4) counseling session limit described in section C above.

G. The provider must complete the counseling checklist and place in the patient records for audit. **View or Print the Arkansas Be Well Referral Form**

Oral surgeons must use procedure code for one 15-minute unit and procedure code for one 30-minute unit when filing claims on the American Dental Association (ADA).

See Section 257.000 of this manual for coverage and benefit limit information.

292.910 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. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and 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.

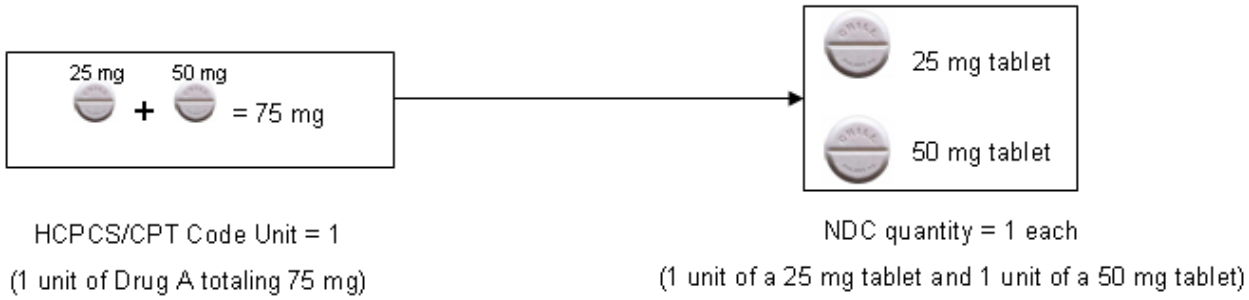
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

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

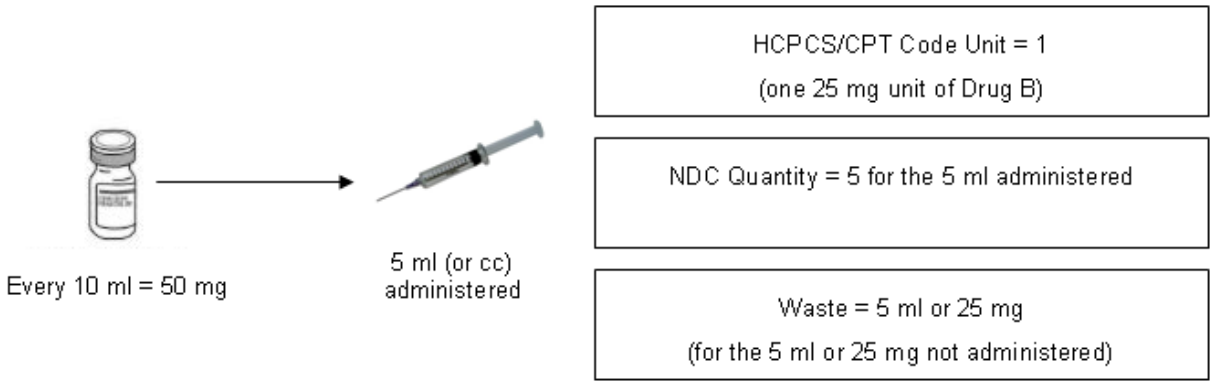
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 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

B. Paper Claims Filing – CMS-1500

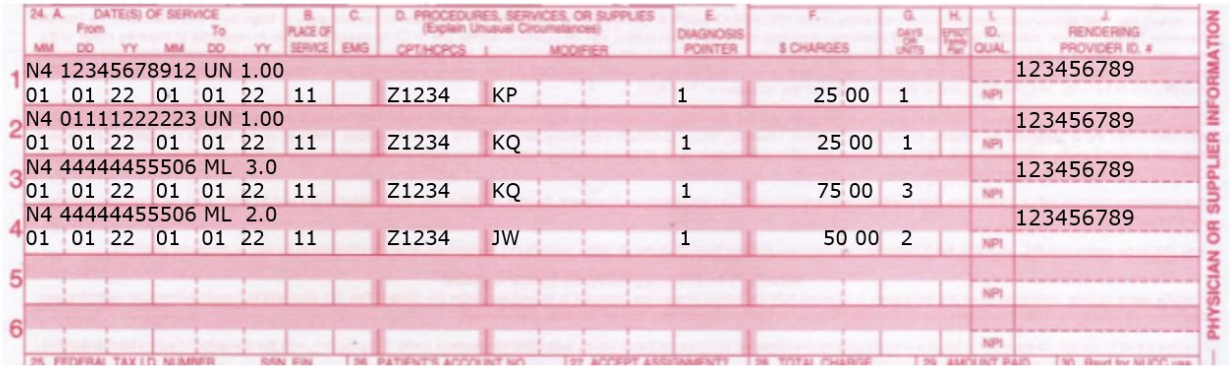
Providers are instructed to bill as follows:

- 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
- 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.

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

Diagram 6



24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 N4 12345678912 UN 1.00											123456789
01 01 22	01 01 22	11		Z1234	KP	1	25 00	1		NPI	
2 N4 01111222223 UN 1.00											123456789
01 01 22	01 01 22	11		Z1234	KQ	1	25 00	1		NPI	
3 N4 44444455506 ML 3.0											123456789
01 01 22	01 01 22	11		Z1234	KQ	1	75 00	3		NPI	
4 N4 44444455506 ML 2.0											123456789
01 01 22	01 01 22	11		Z1234	JW	1	50 00	2		NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

II. 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.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute 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 purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

See Section 292.950 for additional information regarding drug code billing.

292.920 Medication Assisted Treatment (MAT) for Opioid Use Disorder 2-1-24

There are two (2) methods of billing for MAT.

1. Method 1- Inclusive Rate

    a. The inclusive method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 are provided on the same date of service by the same billing group.

        i. For new patients, the provider group shall use HCPCS code, modifier X2 and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all services (Office Visit, counseling, case management, medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

        ii. For established patients requiring continuing follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X2, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X2 modifier with the proper code for the test or screen.

        iii. For established patients requiring maintenance follow-up MAT treatment, the provider group shall use HCPCS code, modifiers U8, X4, and list an Opioid Use Disorder ICD-10 code as primary. The performing provider must be enrolled as a MAT provider and the claim will pay a single rate for all follow-up services as indicated on the treatment plan and set forth at a minimum in Section 230.000 (Office Visit, counseling and medication induction/maintenance, etc). Drug and lab testing/screening will continue to be billed separately, using an X4 modifier with the proper code for the test or screen.

        iv. The specific HCPCS code and modifiers found in the following link are required for billing the inclusive rate. **View or print the procedure codes and modifiers for MAT services**.

2. Method 2 – Regular Fee-for-Service Rates

    a. The regular Fee-for-Service method of billing shall be used when all SAMHSA guideline services as set forth at a minimum in Section 230.000 cannot be provided on the same date of service, or cannot be provided by the same billing group who has the MAT specialized performing provider; therefore, causing some SAMHSA guideline services to be referred elsewhere.

        i. For new patients, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

        ii. For established patients requiring continuing treatment, the MAT provider shall use the appropriate E & M (office visit) code, add modifier X2, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X2 modifier for the screenings required.

        iii. For established patients requiring maintenance treatment, the MAT provider

shall use the appropriate E & M (office visit) code, add modifier X4, and list an Opioid Use Disorder ICD-10 code as primary. The provider shall use the proper Lab and Urine Screening codes plus the additional X4 modifier for the screenings required.

Allowable ICD-10 codes for Opioid Use Disorder may be found here: (**View ICD OUD Codes.**)

Allowable lab and screening codes may be found here: (**View Lab and Screening Codes**.)

Providers utilizing telemedicine, regardless of Method, shall adhere to telemedicine rules listed in Sections 105.190 and 305.000 in addition to those above. The provider at the distance site shall use both the GT modifier and the X2 or X4 modifier on the service claim.

292.930 Drug Treatment for Pediatric PANS and PANDAS 6-1-22

A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:

1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).

B. The drug treatments include off-label drug treatments, including without limitation intravenous immunoglobulin (IVIG).

C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:

1. The drug treatment must be authorized under a Treatment Plan; and
2. The Treatment Plan must be established by the approved PANS/PANDAS provider.

D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. (Add link to AFMC.)

E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services, including PANS and PANDAS procedure codes.

292.940 Radiopharmaceutical Services 2-1-22

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Prior Approval is required before services associated with the use of procedure codes may be provided. To obtain a Prior Approval Letter from the Division of Medical Services Medical Director for Clinical Affairs, the provider must furnish the following documentation (See Section 244.100 and 292.595.):

1. The FDA approved diagnosis clearly stated
2. Treatment failures that the patient has previously experienced
3 The patient's history and physical report

Prior Approval is required before services associated with the use of procedure code may be provided. To obtain Prior Approval, the provider must submit the following documentation:

1. The patient's history and physical

2. A report of the ultrasound or computerized axial tomography (CAT) that was not diagnostic

Prior Approval is required for the service associated with the use of procedure code. To obtain Prior Approval, the provider must submit:

1. A history and physical

2. A report on what other profusion scans have been tried and are non-diagnostic

Some HCPCS laboratory and radiology services are payable only with diagnosis restrictions. For payment, these diagnoses must be entered on the claim.

*List 003 diagnosis codes include (**View ICD Codes.**). Diagnosis List 003 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.

Radiopharmaceutical therapy is covered with prior approval from the Medical Director for Clinical Affairs of the Division of Medical Services. Claims must be filed using procedure code.

1. Claims must be submitted to the Arkansas Medicaid fiscal agent on paper.

2. A copy of the Medical Director for Clinical Affair's approval letter and a copy of the invoice for the monoclonal antibody used must be attached to the claim form.

Refer to Section 244.200 for coverage information and instructions for requesting prior approval.

For coverage information regarding any drug not listed in Section 292.950, please contact the Medicaid Reimbursement Unit. View or print Medicaid Reimbursement Unit contact information.

292.950 Injections, Therapeutic and/or Diagnostic Agents 1-1-23

A. Providers billing the Arkansas Medicaid Program for covered injections should bill the appropriate CPT or HCPCS procedure code for the specific injection administered. The procedure codes and their descriptions may be found in the Current Procedure Terminology (CPT) and in the Healthcare Common Procedural Coding System Level II (HCPCS) coding books.

Injection administration code, is payable for beneficiaries of all ages. May be used for billing the administration of subcutaneous and/or intramuscular injections only. This procedure code cannot be billed when the medication is administered "ORALLY." No fee is billable for drugs administered orally.

Cannot be billed separately for Influenza Virus vaccines or Vaccines for Children (VFC) vaccines.

Cannot be billed to administer any medication given for family planning purposes. No other fee is billable when the provider decides not to supply family planning injectable medications.

Cannot be billed when the drug administered is not FDA approved.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Covered drugs can be billed electronically or on paper. If requested, additional documentation may be required to justify medical necessity. Reimbursement for manually priced drugs is based on a percentage of the average wholesale price.

See Section 292.940 for coverage information of radiopharmaceutical procedure codes.

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs. See Section 292.910 for further information.

Administration of therapeutic agents is payable only if provided in a physician's office, place of service code "11." These procedures are not payable to the physician if performed in any other setting. Therapeutic injections should only be provided by physicians experienced in the provision of these medications and who have the facilities to treat patients who may experience adverse reactions. The capability to treat infusion reactions with appropriate life support techniques should be immediately available. Only one administration fee is allowed per date of service unless "multiple sites" are indicated in the "Procedures, Services, or Supplies" field in the CMS-1500 claim form. Reimbursement for supplies is included in the administration fee. An administration fee is not allowed when drugs are given orally.

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 for therapeutic and chemotherapy administration procedure codes.

See Section 292.940 for radiopharmaceutical drugs.

B. For consideration of payable unlisted CPT/HCPCS drug procedure codes:

1. The provider must submit an electronic or paper claim that includes a description of the drug being represented by the unlisted procedure code on the claim form.
2. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
3. All other billing requirements must be met in order for payment to be approved.

C. **Immunizations**

Physicians may bill for immunization procedures on the CMS-1500 claim form. **View a CMS-1500 sample form.** See Section 292.950 for covered vaccines and billing protocols.

Coverage criteria for all immunizations and vaccines are listed in the **Procedure Code Tables - Arkansas Department of Human Services**.

Influenza virus vaccine through the Vaccines for Children (VFC) program is determined by the age of the beneficiary and obviously which vaccine is used.

The administration fee for all vaccines is included in the reimbursement fee for the vaccine CPT procedure code.

D. **Vaccines for Children (VFC)**

The Vaccines for Children (VFC) Program was established to generate awareness and access for childhood immunizations. Arkansas Medicaid established new procedure codes for billing the administration of VFC immunizations for children under the age of 19 years of age. To enroll in the VFC Program, contact the Arkansas Division of Health. Providers may also obtain the vaccines to administer from the Arkansas Division of Health. **View or print Arkansas Division of Health contact information.**

Medicaid policy regarding immunizations for adults remains unchanged by the VFC Program.

Vaccines available through the VFC Program are covered for Medicaid-eligible children. Administration fee only is reimbursed. When filing claims for administering VFC vaccines, providers must use the CPT procedure code for the vaccine administered. Electronic and paper claims require modifiers **EP** and **TJ.** ARKids First-B beneficiaries are not eligible for the Vaccines for Children (VFC) Program; however, vaccines can be obtained to

administer to ARKids First-B beneficiaries who are under the age of 19 by contacting the Arkansas Department of Health and indicating the need to order ARKids-B SCHIP vaccines. **View or print the Department of Health contact information**.

When vaccines are administered to beneficiaries of ARKids First-B services, only modifier **SL** must be used for billing. Any additional billing and coverage protocols are listed under the specific procedure code in the tables section of this manual. See Part F of this section.

E. **Billing of Multi-Use and Single-Use Vials**

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

1. 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.
2. 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.
    a. **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.
    b. **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.
    c. **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.

See Section 292.910 for additional information regarding National Drug Code (NDC) billing.

F. Process for Obtaining a Prior Authorization Number from the DHS contracted Prior Authorization vendor.

Covered drugs may be billed electronically or on a paper claim.

A Prior Authorization number (PA) must be requested before treatment is initiated for any drug, therapeutic agent or treatment that indicates a Prior Authorization is required in a provider manual or an official Division of Medical Services correspondence.

The Prior Authorization requests should be completed using the approved contracted vendor Prior Authorization request form. **(View or print PA form.)**

A decision letter will be returned to the provider by fax or *e* within five (5) business days.

If approved, the Prior Authorization number must be appended to all applicable claims, within the scope of the approval and may be billed electronically or on a paper claim with additional documentation when necessary.

Denials will be subject to reconsideration if received by the contracted vendor with additional documentation within fifteen (15) business days of date of denial letter.

A reconsideration decision will be returned within five (5) business days of receipt of the reconsideration request.

G. Contact Information for Obtaining Prior Authorization

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.

*Procedure code requires paper billing with applicable attachments and must follow NDC protocol. (See Section 292.910 for NDC protocol.)

See Sections 261.000 – 261.220 for prior authorization procedures.

See Section 244.100 for instructions regarding obtaining a Prior Approval Letter.

List 603 diagnosis codes include: (**View ICD Codes**.) Diagnosis List 603 restrictions apply to ages 21y and above unless otherwise indicated in the age restriction column.