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222.000 ASC Procedures ~~Outpatient Surgeries~~ That Require Medical Review, Prior Authorization, and Diagnosis Code Restriction ~~11-1-17~~6-1-20

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

~~11920~~	~~11921~~	~~11950~~	~~11951~~	~~11952~~	~~11954~~	~~15775~~	~~15776~~
~~15780~~	~~15781~~	~~15782~~	~~15783~~	~~15789~~	~~15819~~	~~15820~~	~~15821~~
~~15822~~	~~15823~~	~~15824~~	~~15825~~	~~15826~~	~~15828~~	~~15829~~	~~15876~~
~~15877~~	~~15878~~	~~15879~~	~~17360~~	~~17380~~	~~21073~~	~~26341~~	~~27279~~
~~28531~~	~~36468~~	~~43886~~	~~43887~~	~~43888~~	~~54401~~	~~54405~~	~~54406~~
~~54408~~	~~54410~~	~~54900~~	~~54901~~	~~55870~~	~~56805~~	~~58321~~	~~58322~~
~~58323~~	~~58970~~	~~58974~~	~~58976~~	~~59200~~	~~64566~~	~~C9724~~	

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

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

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Outpatient Surgery Abortion Codes That Require Prior Authorization		
59840	59841	59866

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

~~242.411 Other Covered Injections and Immunizations with Special Instructions 11-1-17~~

~~For dates of service on or after November 1, 2017, the following procedure codes require prior authorization or a diagnosis restriction.~~

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

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

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

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

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

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

Procedure Code	Diagnosis	Diagnosis List	Review	PA
A9520	No	No	No	No
A9586	No	No	No	No
C9025	No	List 103	No	No
C9026	No	No	No	Yes
C9027	No	No	No	Yes
C9132	No	No	Yes	No

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

Procedure Code	Diagnosis	Diagnosis List	Review	PA
C9257	No	No	No	Yes
C9442	No	No	No	Yes
C9445	No	No	No	No
C9449	No	No	No	Yes
C9450	No	No	No	Yes
C9451	J10.1	No	No	No
C9453	No	No	No	Yes
C9454	No	No	No	Yes
C9455	No	No	No	Yes
J0401	No	List 157	No	Yes
J0717	No	No	No	Yes
J1322	No	No	No	Yes
J1556	No	No	Yes	No
J1602	No	No	Yes	No
J3060	No	No	Yes	Yes
J3101	No	No	Yes	No
J7316	No	No	Yes	Yes
J7321	No	No	No	Yes
J7323	No	No	No	Yes
J7324	No	No	No	Yes

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Procedure Code	Diagnosis	Diagnosis List	Review	PA
J7325	No	No	No	Yes

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

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

Procedure Code	Diagnosis	Diagnosis List	Review	PA
J7327	No	No	No	Yes
J7336	No	No	No	Yes
J9047	No	No	No	Yes
J9262	No	No	No	Yes
J9301	No	No	No	Yes
J9306	No	No	No	Yes
J9354	No	No	No	Yes
J9371	No	No	No	Yes
J9400	No	No	Yes	Yes
Q3027	No	List 166	No	Yes
Q9975	No	No	No	Yes
Q9978	No	No	No	Yes

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