SECTION II - PROSTHETICS

CONTENTS

200.000 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Prosthetics Providers 11-1-09

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

Durable Medical Equipment, Prosthetics, Orthotics and Medical Suppliers must be enrolled in the Title XVII (Medicare) Program as a durable medical equipment/oxygen, orthotic appliances or prosthetic device provider. A copy of the verification letter that reflects the provider's Medicare supplier number must be submitted with the provider application and Medicaid contract. A separate letter and Medicare supplier number must be submitted for each Medicaid service location.

Providers must provide Arkansas Medicaid proof of DME Medicare accreditation and surety bond dated on or after October 1, 2009. New Providers will be required to submit Medicare accreditation and surety bond upon enrollment.

NOTE: The orthotics/prosthetics provider should maintain accreditation by the American Board for Certification in Orthotics and Prosthetics. The provider should ensure that staff providing patient care (including but not limited to direct care, evaluations, diagnoses, fabrication fittings and follow up care) are accredited by the American Board for Certification in Orthotics and Prosthetics and meet all national licensing and certification requirements and all licensing and certifications required by the State of Arkansas.

201.100 Providers in Arkansas and Bordering States 10-13-03

Providers 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 above.

201.110 Routine Services Provider 12-15-14

A. Routine services providers may be enrolled in the program as providers of routine services.

B. Reimbursement may be available for durable medical equipment/oxygen, orthotic appliances and prosthetic devices covered in the Arkansas Medicaid Program.

C. Claims must be filed according to the specifications in this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

201.200 Providers in Non-Bordering States 3-1-11

Providers in non-bordering states may enroll only as limited services providers.

201.210 Limited Services Provider 3-1-11

A. Limited services providers may enroll in the Arkansas Medicaid program to provide prior authorized or emergency services only.

B. Emergency services are defined as inpatient or outpatient hospital services that a prudent layperson with an average knowledge of health and medicine would reasonably believe are necessary to prevent death or serious impairment of health and which, because of the danger to life or health, require use of the most accessible hospital available and equipped

to furnish those services.
Source: 42 U.S. Code of Federal Regulations §422.2 and §424.101.

C. Prior authorized services are those that are medically necessary and not available in Arkansas. Each request for these services must be made in writing, forwarded to the Division of Medical Services, Utilization Review Section and approved before the service is provided. See Section 220.000 of this manual for instructions for obtaining prior authorization. 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 receipt and approval of the provider application and Medicaid contract. **View or print the Utilization Review Section contact information**. **View or print the provider enrollment and contract package (Application Packet).** **View or print Medicaid Provider Enrollment Unit contact information.**

D. Limited services provider claims will be manually reviewed prior to processing to ensure that only emergency or prior authorized services are approved for payment. These claims should be mailed to the Arkansas Division of Medical Services Program Communications Unit. **View or print the Arkansas Division of Medical Services Program Communications Unit contact information**.

Providers such as pharmacies, home health agencies or hospitals which have agreements with Medicaid to provide services to Medicaid beneficiaries must complete a separate Medicaid contract and provider application to provide durable medical equipment/oxygen, orthotic appliances and prosthetic devices. A separate provider number will be assigned.

202.000 The Prosthetics Provider Role in the Child Health Services (EPSDT) Program 10-13-03

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.

If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services will also be considered for reimbursement if the service is medically necessary and permitted under federal Medicaid regulations.

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

203.000 Documentation Requirements 11-1-09

Prosthetics providers must keep and properly maintain written records. Along with the required enrollment documentation, which is located in Section 141.000, the following records must be included in the beneficiary's case file maintained by the provider.

203.100 Documentation in Beneficiary's Case Files 9-1-18

The provider must develop and maintain sufficient written documentation to support each service for which billing is made. All entries in a beneficiary's file must be signed and dated by the individual who provided the service, along with the individual's title. The documentation must be kept in the beneficiary's case file.

Documentation should consist of, at a minimum, material that includes:

A. An audit trail between the prosthetics provider, the beneficiary, the beneficiary's primary care physician and advanced practice registered nurse and the Division of Medical Services.

B. When applicable, documentation including the request for and approval of prior authorization and/or the request for and approval of extension of benefits for services provided.

C. Prescriptions for prosthetics services, signed and dated by the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice.

D. The prosthetics provider's signed and dated:

1. Certification that used equipment is reconditioned, is in good working order and has no defects in workmanship or material
2. The beneficiary's consent to receive services
3. Notification of termination of prosthetics services
4. Documentation to reflect that necessary training and orientation has been provided to the beneficiary and any other applicable persons
5. Any additional or special documentation, requested in writing, that is needed to provide fair and impartial review of individual cases, requested in writing.

203.200 Reserved 11-1-09

203.300 Reserved 11-1-09

204.000 Electronic Signatures 10-8-10

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

210.000 PROGRAM COVERAGE

211.000 Scope 1-1-21

There are several broad areas of service provision in the Prosthetics manual. Services provided include durable medical equipment, which also encompasses specialized wheelchairs, wheelchair seating systems, specialized rehabilitation equipment and the speech generating device. Other programs covered in the Prosthetics manual include medical supplies, nutritional formulas, diapers and underpads, prosthetic devices and orthotic appliances.

211.100 Condition for Provision of Services 9-1-18

The following conditions must be met for the provision of services:

A. The beneficiary must reside in the state of Arkansas.

B. The individual must be an Arkansas Medicaid beneficiary.

C. Services must be medically necessary and prescribed by the beneficiary's primary care physician (PCP) or Advanced Practice Registered Nurses (APRN) unless the beneficiary is exempt from PCP requirements. A PCP referral is required. See Section I.

D. A beneficiary is accepted for services on the basis of a reasonable expectation that his or her medical needs can be adequately met by the provider.

E. When applicable, Form DMS-679, titled *Medical Equipment Request for Prior Authorization and Prescription*, must be utilized when requesting prior authorization for wheelchairs, wheelchair seating systems, wheelchair repairs, for eligible Medicaid beneficiaries. **View or print form DMS-679 and instructions for completion**.

F. When applicable, form DMS-679A, titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be utilized when requesting prior authorization for some medical supplies (i.e.: compression burn garments), orthotics appliances, prosthetic devices and durable medical equipment, excluding wheelchairs, wheelchair seating systems or wheelchair repairs, when these items are prescribed for eligible Medicaid beneficiaries. **View or print form DMS-679A and instructions for completion.**

G. When applicable, form DMS-602, titled *Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21*, must be utilized when requesting extension of benefits for medical supplies for beneficiaries under age 21. **View or print form DMS-602 and instructions for completion**.

H. When applicable, form DMS-699, titled *Request for Extension of Benefits*, must be utilized when requesting extension of benefits for diapers and underpads for eligible beneficiaries ages three and older. **View or print form DMS-699**.

I. The beneficiary must reside in his or her own dwelling, an apartment, relative's or friend's home, boarding home, residential care facility or any other type of supervised living situation that is not required to provide prosthetics services as part of the facility's participation agreement as a service provider.

A beneficiary's place of residence for services may not include a hospital, skilled nursing facility, intermediate care facility or any other supervised living situation that is required to provide prosthetics services under a provider agreement or contract as required by federal, state or local regulation.

211.200 Physician's Role in the Prosthetics Program 9-1-18

At least once every 6 months, the primary care physician or advanced practice registered nurse within the scope of practice must certify the medical necessity for services and prescribe them by signing and dating a prescription. When applicable, the primary care physician or advanced practice registered nurse within the scope of practice must complete a prior authorization form; either a *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) when prescribing services for wheelchairs and wheelchair seating systems, or wheelchair repairs or a form DMS-679A, titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components,* when prescribing orthotic appliances, prosthetic devices or durable medical equipment. **View or print form DMS-679 and instructions for completion.** **View or print form DMS-679A and instructions for completion.**

211.300 Prosthetics Service Provision 8-1-21

At least once every six (6) months, the prosthetics provider must receive a prescription for prosthetics services from either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and, when applicable:

A. Prepare a *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) for wheelchairs, wheelchair seating systems or wheelchair repairs for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679 and instructions for completion.**

B. Prepare a Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components for some medical supplies (i.e.: compression burn garments), orthotic appliances, prosthetic devices and durable medical equipment for beneficiaries twenty-one (21) years of age or older and for specified services for beneficiaries under age twenty-one (21). **View or print form DMS-679A and instructions for completion.**

C. Send the prepared request for prior authorization to either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice for prescriptions

D. Send the completed *Medical Equipment Request for Prior Authorization and Prescription Form* (form DMS-679) to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.https://mygainwell.sharepoint.com/teams/ILU/Shared Documents/General/ILU_File_Library/ProvDocs/Manuals/PROSTHET/Links/afmc.doc**

E. Send the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print contact information for how to obtain information regarding submission processes.**

As necessary, the provider must:

A. Deliver and set up the prescribed equipment in the beneficiary's home,

B. Teach the beneficiary, families and caregivers the correct use and maintenance of equipment,

C. Repair equipment within three (3) working days of notification,

D. Retrieve from the beneficiary's home equipment no longer prescribed for the beneficiary and

E. Provide necessary documentation.

211.400 Prescription and Referral Renewal 9-1-18

At least once every 6 months, but within 30 working days before the end of currently prescribed or prior authorized prosthetics services, the prosthetics provider must obtain a new prescription from either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and, if applicable, send a new prior authorization form to the applicable entity. The primary care physician or advanced practice registered nurse within the scope of practice must initially review either form DMS-679 or form DMS-679A, and, based upon the physician's certification of medical necessity, prescribe services. Form DMS-679 or form DMS-679A must then be reviewed by the applicable entity and services must be prior authorized. If services are prescribed, and when applicable, prior authorized, services may be furnished for a maximum of 6 months from the date of the prescription.

211.500 Service Initiation Delays 9-1-18

If all prescribed prosthetics services are not begun by the prosthetics provider within 30 working days of the prescription date, the prosthetics provider must notify the beneficiary and either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice in writing and explain the delay. The provider must retain documentation justifying the service delay.

211.600 Termination of Services 9-1-18

If prosthetics services are terminated, the provider must notify either the beneficiary's primary care physician or advanced practice registered nurse within the scope of practice and the beneficiary (if not deceased) in writing, within 10 working days of the termination, documenting the effective date of and reasons for the termination.

211.700 Exclusions 8-1-05

Services that are not covered under the Arkansas Medicaid Prosthetics Program include but are not limited to:

A. Over-the-counter items provided through the Arkansas Medicaid Pharmacy Program (except as specified).

B. Over-the-counter drugs (except as specified).

C. Products that bear the Federal legend "Caution: Federal Law Prohibits Dispensing Without A Prescription" (except as specified).

D. Specialized wheelchair equipment that has been previously purchased by any payer. Specialized wheelchair equipment may not be reordered unless the patient's condition changes and necessitates a change in prescription. This change in condition must be thoroughly documented.

E. Wheelchairs for individuals under 21 years of age within two years of the purchase of a specialized wheelchair.

F. Wheelchairs for individuals age 21 and over within five years of the purchase or rental of a wheelchair.

G. Foodstuffs.

H. Hyperalimentation.

I. Services that duplicate any other service provided to the patient or that replace existing patient supports.

211.800 Electronic Filing of Extension of Benefits 8-1-21

Form DMS-699, titled *Request for Extension of Benefits*, serves as both a request form and a notification of approval or denial of extension of benefits when requesting diapers and underpads for beneficiaries age three (3) and older. If the benefit extension is approved, the form returned to the provider will contain a Benefit Extension Control Number. The approval notification will also list the procedure codes approved for benefit extension, the approved dates or date-of-service range and the number of units of service (or dollars, when applicable) authorized.

Upon notification of a benefit extension approval, providers may file the benefit extension claims electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to the Utilization Review Section will be necessary only when the Benefit Extension Control Number expires or when a beneficiary's need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.

212.000 Services Provided

212.100 Diapers and Underpads for Individuals Age 3 and Older 6-1-09

Diapers and underpads are covered by the Arkansas Medicaid Program but are benefit limited and must be medically necessary.

A. Medical Necessity

Diaper services must be medically necessary and the medical condition that prohibits the ability to potty train must be documented. Only patients with a medical condition that results in incontinence of the bladder and/or bowel may receive diapers through the Home Health and Prosthetics Programs. This coverage does not apply to infants who would be in diapers regardless of their medical condition. Medicaid does not cover underpads or diapers for beneficiaries under the age of 3 years.

B. Benefit Limit

The benefit limit for diapers and underpads is $130.00 per month, per beneficiary, for diapers of any size and underpads. The benefit limit applies to any diaper or underpad, or any combination, whether provided through the Prosthetics Program, the Home Health Program or both. The limit on diapers and underpads is separate from the limit established for home health and durable medical equipment (DME) medical supplies.

The benefit may be extended with proper documentation.

C. Extension of Benefits for Diapers and Underpads

To obtain an extension of benefits for diapers and underpads, the following information must be submitted to the Prosthetics Services Reviewer, DMS Utilization Review. **View or print the DMS Utilization Review contact information**.

1. A completed Medicaid Form DMS-699, titled Request for Extension of Benefits for the requested time period prior to the delivery of the product. **View or print form DMS-699.**
2. Documentation supported by the medical record substantiating the medical necessity of an extension of benefits, including the prescription(s) for all prescribed incontinence products.

212.200 Durable Medical Equipment (DME), All Ages 8-1-05

Durable medical equipment (DME) is equipment that can withstand repeated use and is used to serve a medical purpose.

Depending on the item involved, DME may be purchased for or by a beneficiary or may be rented. The equipment may be new or, in special circumstances, used equipment.

212.201 (DME) Apnea Monitors for Infants Under Age 1 8-1-21

Arkansas Medicaid covers apnea monitors only for infants less than one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

For the initial certification, the prescribing physician must sign form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The physician’s signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be in consultation with a neonatologist or pulmonologist.

As necessary, the primary care physician's (PCP’s) name and provider number must also be indicated on DMS-679A titled Prescription and Prior Authorization Request for Medical

Equipment Excluding Wheelchairs and Wheelchair Components. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

A prior authorization request for an apnea monitor must be submitted to DHS or its designated vendor on form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. **View or print form DMS-679 and instructions for completion.** **View or print contact information for how to obtain information regarding submission processes.**

Prior authorization is not required for the initial sixty-day period of use of the monitor. If the apnea monitor is needed longer than an initial sixty-day period, prior authorization is required.

A new prescription, documentation of compliance during the initial sixty-day period and proof of medical necessity for the continuation of monitoring are required.

Documentation of compliance and the download monitor report must accompany the request for continued use of the apnea monitor following the initial sixty-day time period.

The following criteria, established by the *American Academy of Pediatrics*, are to be used to evaluate the need for an apnea monitor after the initial sixty-day period:

A. Evidence exists that preterm infants are at greater risk of extreme apnea episodes until approximately forty-three (43) weeks post conceptual age. Monitoring may be indicated until forty-three (43) weeks post conceptual age unless extreme episodes persist beyond that time. Home monitoring may be indicated for other selected groups of infants, as well.

B. Home cardiorespiratory monitoring may be warranted for premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia after hospital discharge.

   The use of home cardiorespiratory monitoring in this population should be limited to approximately forty-three (43) weeks post conceptual age or after the cessation of extreme episodes, whichever comes last.

C. Home cardiorespiratory monitoring may be warranted for infants who are technology dependent (tracheostomy, supplemental oxygen, continuous positive airway pressure, etc.), have unstable airways, have rare medical conditions affecting regulation of breathing or have symptomatic chronic lung disease.

   In many of these cases, the use of pulse oximetry monitoring is superior and preferred over simple cardiorespiratory monitoring.

D. Other infants who may benefit from home cardiorespiratory home monitoring include:

   1. Infants who have experienced an apparent life-threatening event (ALTE)

      An ALTE is defined as “an episode that is frightening to the observer and is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking or gagging.”

   2. Infants with tracheotomies or anatomic abnormalities that may compromise their airway

   3. Infants with metabolic or neurological abnormalities affecting respiratory control

   4. Infants with chronic lung disease of prematurity (bronchopulmonary dysplasia, BPD), especially those requiring some form of respiratory support

E. Parents or caregivers must be counseled regarding the purpose of the home cardiorespiratory monitoring and realistic expectations of what it can and cannot contribute to an infant’s well being.

1. When monitoring is used in the home, parents and other caregivers must be trained in observation techniques, operation of the monitor, and infant cardiopulmonary resuscitation prior to the use of the monitor.
2. Medical and technical support staff should always be available for direct or telephone consultation.

F. Duration and discontinuation of home cardiorespiratory monitoring

1. When home monitoring is prescribed for apnea/bradycardia in preterm infants, the physician should establish a plan for review of clinical and event (download) data at forty-three (43) weeks post conceptual age. If monitoring is to be continued beyond that time, documentation should be provided as to why it should be continued as well as a plan for reevaluation.
2. Infants whose mothers have unsure dates (uncertain post-conceptual age) may be monitored until the infants are at least forty-three (43) weeks post conceptual age.
3. When home monitoring is prescribed for indications other than apnea/bradycardia in preterm infants, continuation of monitoring will be reviewed on a case-by-case basis.
4. Discontinuation of home monitoring should be a clinical decision based on a combination of clinical data and cardiorespiratory monitor event data.
5. Decisions regarding discontinuation of home monitoring should NOT be based on single-night pneumograms, which have no proven predictive value in this setting.

212.202 (DME) Augmentative Communication Device (ACD), All Ages 8-1-21

The augmentative communication device (ACD) is covered for beneficiaries of all ages. Coverage for beneficiaries under twenty-one (21) years of age must result from an EPSDT screen. There is a $7,500.00 lifetime benefit for augmentative communication devices. When a beneficiary who is under age twenty-one (21) has met the lifetime benefit and it is determined that additional equipment is medically necessary, the provider may request an extension of benefits by submitting form DMS-679A. **View or print form DMS-679A.**

The ACD is also covered for Medicaid beneficiaries twenty-one (21) years old and older. Prior authorization is required on the device and on repairs of the device. For beneficiaries who are age twenty-one (21) and above, a $7,500.00 lifetime benefit without benefit extensions applies.

The Arkansas Medicaid Program will not cover ACDs that are prescribed solely for social or educational development.

Training in the use of the device is not included and is not a covered cost.

Prior authorization **must** be requested for repairs of equipment or associated items after the expiration of the initial maintenance agreement.

Form DMS-679A, titled *Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* serves as a request form when requesting extension of benefits for the augmentative communication device. **View or print contact information for how to obtain information regarding submission processes for augmentative communication device.**

The form should be accompanied by:

A. A current augmentative communication evaluation completed by a multidisciplinary team consisting of, at least, a speech/language pathologist and an occupational therapist. The team may consist of a physical therapist, regular and special educators, caregivers and parents. The speech-language pathologist must lead the team and sign the ACD evaluation report. (For the qualifications of the team members, see the Hospital/Critical Access Hospital/End Stage Renal Disease provider manual.)

1. The team must use an interdisciplinary approach in the evaluation, incorporating the goals, objectives, skills and knowledge of various disciplines. The team must use at least three ACD systems, with written documentation of each usage included in the ACD assessment.
2. The evaluation report must indicate the medical reason for the ACD. The report must give specific recommendations of the system and justification of why one system is more appropriate than another system.
3. The evaluation report must be submitted to the prosthetics provider who will request prior authorization for the ACD.

B. Written denial from the insurance company if the individual has other insurance.

Benefit Limit

Arkansas Medicaid limits augmentative communication devices to a $7500 lifetime benefit. When the beneficiary under age twenty-one (21) has met the limit and it is determined that additional equipment is necessary, the provider may request an extension of benefits. DHS or its designated vendor reviews and determines approval or denial for an extension of the lifetime benefit. **View or print contact information for how to obtain information on how to submit the request.**

The provider must submit a form DMS-679A, a completed Medicaid claim and medical records substantiating medical necessity that the beneficiary cannot function using his or her existing equipment and whether the equipment can be repaired or needs repair. **View or print form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.***

212.203 Cochlear Implants for Beneficiaries Under Age 21 2-1-22

Cochlear implants are covered through the Arkansas Medicaid Physician or Prosthetics Programs for eligible Medicaid beneficiaries under the age of 21 years through the Child Health Services (EPSDT) program when prescribed by a physician.

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 not considered medically necessary and will not be approved.

A. 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 processors 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.

B. Personal FM (Frequency Modulation) Systems

Arkansas Medicaid will reimburse for a personal FM system for use by a cochlear implant beneficiary when prior authorized and not available from 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.

C. Replacement, Repair, Supplies

The repair 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.

D. Prior Authorization

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 form **DMS-679A**. 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. **View or print form DMS-679A and instructions for completion.**

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.

The following procedure codes must be prior authorized. 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.

The table below contains new and existing HCPCS procedure codes for FM systems for use with cochlear implant and replacement cochlear implant parts.

NOTE: Coverage and billing requirements for the physician provider for cochlear device implantation are unchanged.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

*Denotes paper claim

See Section 242.155 for information on billing and reimbursement for FM system and replacement cochlear implant parts.

212.204 (DME) Electronic Blood Pressure Monitor and Cuff for Beneficiaries of All Ages 8-1-21

Arkansas Medicaid covers the automatic electronic blood pressure monitor for beneficiaries of all ages as a rental-only item. A provider must substantiate that an accurate blood pressure

reading cannot be obtained by using a regular blood pressure monitor. Providers must also supply one (1) disposable blood pressure cuff each month.

Prior authorization is required for the use of this item. Providers may request prior authorization by submitting form DMS-679A, Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

212.205 (DME) Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit for Beneficiaries Under Age 21 8-1-21

The request for an enteral nutrition pump is covered on a case-by-case basis for beneficiaries under age twenty-one (21) who require supplemental feeding because of medical necessity. Sufficient medical documentation must be provided to establish that the enteral nutrition infusion pump is medically necessary (e.g., supplemental feeding must be given over an extended period of time due to reflux, cystic fibrosis, etc.). The PCP or appropriate physician specialist must prescribe the pump, citing the medical reason that bolus feeds are inappropriate.

Reimbursement for use in the home may be made for the pump supply kit when the feeding method involves an enteral nutrition infusion pump. The pump supply kit and the infusion pump require prior authorization from DHS or its designated vendor using form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* **View or print contact information for how to submit the request**. **View or print form DMS-679A and instructions for completion.**

The enteral feeding pump supply kit, necessary for the administration of the nutrients when the feeding method involves an enteral nutrition infusion pump, is reimbursed on a per-unit basis with one (1) day equaling one (1) unit of service. A maximum of one (1) unit per day is allowed. The pump supply kit includes pump sets, containers and syringes necessary for administration of the nutrients.

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid. Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. **View or print form DMS-679A and instructions for completion.**

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. Form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be used to request prior authorization. **View or print contact information for how to submit the request**. **View or print form DMS-679A and instructions for completion.**

212.206 Home Blood Glucose Monitor and Supplies, All Ages 8-1-24

A. Effective 4/1/2024, Medicaid beneficiaries are eligible for diabetic and blood sugar testing supplies processed as a pharmacy claim submission by pharmacies or DME providers. Home blood sugar meters and supplies (strips, lancets, calibration solution, etc.) are available without a prior authorization. **See the DHS Pharmacy Vendor's website for specific information for coverage details**.

B. Beneficiaries with Medicare Part B benefits continue to be serviced under the durable medical equipment (DME) program.

212.207 Insulin Pump and Supplies, All Ages 8-1-24

Insulin pumps and supplies are covered by Arkansas Medicaid for beneficiaries of all ages. Effective 4/1/2024, patch or tubeless insulin pumps are processed as a pharmacy claim

submission by pharmacies or DME providers while traditional insulin pumps requiring tubing and cannula type supplies remain processed as a medical claim. Beneficiaries with Medicare Part B benefits continue to be serviced for all of their needs under the DME program.

Prior authorization is required for the insulin pump. A prescription and proof of medical necessity are required. The patient must be educated on the use of the pump, but the education is not a covered service.

Insulin is covered through the prescription drug program.

The following criteria will be utilized in evaluating the need for the insulin pump:

A. Insulin-dependent diabetes that is difficult to control.

B. Fluctuation in blood sugars causing both high and low blood sugars in a patient on at least three (3), if not four (4), injections per day.

C. Beneficiary's motivation level in controlling diabetes and willingness to do frequent blood glucose monitoring.

D. Beneficiary's ability to learn how to use the pump effectively. This will have to be evaluated and documented by a professional with experience in the use of the pump.

E. Determination of the beneficiary's suitability to use the pump should be made by a diabetes specialist or endocrinologist.

F. Beneficiaries not included in one (1) of these categories will be considered on an individual basis.

Prior authorization requests for traditional insulin pumps and supplies (cannula, tubing) must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

When submitting prior authorization requests for the patch or tubeless insulin pumps see the **DHS Pharmacy Vendor's website** for specific information for coverage details.

212.208 Continuous Glucose Monitors 8-1-24

A. Effective 4/1/2024, continuous glucose monitors (CGMs) are processed as a pharmacy claim submission by pharmacies or DME providers. Beneficiaries must meet the following criteria for coverage:

1. Either:
   a. A presence of type 1 diabetes or any other type of diabetes with the use of insulin; or
   b. A presence of type 1 diabetes or any other type of diabetes with evidence of Level 2 or Level 3 hypoglycemia; or
   c. Diagnosis of glycogen storage disease type 1a; or
   d. Use of an insulin pump; and
2. Regular follow-up with a healthcare provider at a minimum every six (6) months to assess for ongoing benefit.
3. **See the DHS Pharmacy Vendor's website** for specific information for coverage details.

B. Definition. As used in this section, "continuous glucose monitor" means an instrument or device, including repair and replacement parts, that:

1. Is designed and offered for the purpose of aiding an individual with diabetes;
2. Automatically estimates blood glucose levels, also called blood sugar, throughout the day and night;
3. Is generally not useful to an individual who has not been diagnosed with diabetes.

Beneficiaries with Medicare Part B benefits continue to be serviced under the DME program.

212.209 (DME) Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and Supplies for Beneficiaries of All Ages 12-1-20

The Arkansas Medicaid Program reimburses for the Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and supplies for Medicaid-eligible beneficiaries of all ages. Prior authorization (PA) from DHS or its designated vendor is required.

When requesting prior authorization, form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components*, must be completed and sent, along with sufficient medical documentation. **View or print contact information for how to submit the request.**

The Low-Profile Kit is benefit-limited to two (2) per state fiscal year (SFY). The accessories, extension sets, and adapters are covered under the $250 medical supply benefit limit.

Benefit extensions will be considered on a case-by-case basis if proven to be medically necessary.

212.210 DME Low-Profile Percutaneous Cecostomy Tube (Low-Profile Button) for Beneficiaries of All Ages 2-1-22

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following diagnosis codes. **(View ICD codes.)**

The Low-Profile Button for a Percutaneous Cecostomy Tube requires use of the following CPT codes:

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

212.211 Reserved 8-1-05

212.212 (DME) Specialized Rehabilitative Equipment, All Ages 8-1-21

Arkansas Medicaid covers specialized rehabilitative equipment for Medicaid-eligible beneficiaries of all ages.

Some items of specialized equipment require prior authorization from DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request.**

212.213 (DME) Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Two (2) Years of Age and Older 1-1-23

Arkansas Medicaid covers specialized wheelchairs and wheelchair seating systems for individuals two (2) years of age and older.

Some items of specialized equipment require prior authorization from DHS or its designated vendor. **View or print form DMS-679 and instructions for completion.** **View or print contact information for how to submit the request**.

212.214 Reserved 8-1-05

212.300 Medical Supplies, All Ages 7-1-17

The Arkansas Medicaid Program reimburses home health providers and prosthetics providers for covered medical supplies up to a maximum of $250.00 per month, per beneficiary. The $250.00 may be provided by the Home Health program, the Prosthetics program or a combination of the two.

A beneficiary may not receive more than a total of $250.00 of supplies per month unless an extension has been granted. Extensions will be considered for beneficiaries under age 21 in the Child Health Services (EPSDT) program if documentation verifies medical necessity.

A provider must request an extension of the benefit limit for a Medicaid beneficiary under age 21 by completing the Request for Extension of Benefits for Medical Supplies for Medicaid Recipients Under Age 21 (form DMS-602.) **View or print form DMS-602 and instructions for completion.**

The Arkansas Medicaid program covers medical supplies using a specific HCPCS procedure code for each specific item. Only supply items that are listed and have a corresponding payable HCPCS procedure code are covered.

Supplies are healthcare-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, and that are required to address an individual medical disability, illness or injury.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in the absence of a disability, illness or injury; can withstand repeated use; and can be reusable or removable. Medical coverage of equipment and appliances is not restricted to items covered as durable medical equipment in the Medicare program.

Arkansas has a list of preapproved medical equipment, supplies and appliances for administrative ease, but the state is prohibited from having absolute exclusions of coverage on medical equipment, supplies or appliances. Items not available on the preapproval list may be requested on a case-by-case basis. When denying a request, the state must inform the beneficiary of the right to a fair hearing.

212.400 Nutritional Formulae for Individuals Under Age 21 8-1-05

Nutritional formulae may be covered by the Arkansas Medicaid Program when prescribed by a physician and documented as medically **necessary for beneficiaries under age 21 participating in the Child Health Services (EPSDT) Program.** The Women, Infants and Children Program (WIC) must be accessed first for individuals who are age 0 through age 5.

Nutritional formula may not be billed for the same beneficiary by more than one provider or in more than one program (e.g., Prosthetics and Hyperalimentation) for the same date of service.

Covered formulae represent the nutritional supplements most requested for medical purposes. However, if none of the formulae are appropriate and another formula is prescribed by a physician as a result of Child Health Services (EPSDT) screening, the prescribed formula will be reviewed for medical necessity.

Formulae are covered as nutritional supplements rather than as the sole source of nutrition. Beneficiaries who require enteral nutrition as the sole source of nutrition, with the formulae being administered through a nasogastric, jejunostomy or gastrostomy tube, should be referred to a hyperalimentation provider enrolled in the Medicaid Program.

One unit of service equals 100 calories with an allowable maximum of 30 units per day. This is a separate benefit limit from the limit established for medical supplies. Supplies provided in conjunction with the nutritional formulae through the Prosthetics Program must be billed under the medical supply codes, if those supplies are covered by the program.

There are certain nutritional formulae available to eligible beneficiaries through the WIC Program and the Food Stamp Program. These two programs should be accessed by beneficiaries prior to requesting Medicaid reimbursement for nutritional formulae. The coverage of these formulae through the Medicaid Program is limited to beneficiaries requiring nutrition therapy due to medical necessity and only when prescribed by a physician.

212.500 Food Thickeners, All Ages 8-1-05

Arkansas Medicaid covers food thickeners for Medicaid-eligible individuals who have impaired swallowing and a risk of food aspiration.

Food thickeners are not subject to the $250 benefit limit for other medical supplies.

212.600 Orthotic Appliances and Prosthetic Devices, All Ages 8-1-21

A. The Arkansas Medicaid Program covers orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21) in the Child Health Services (EPSDT) Program. Providers of orthotic appliances and prosthetic devices may be reimbursed by the Arkansas Medicaid Program when the items are prescribed by a physician and documented as medically necessary for beneficiaries under age twenty-one (21) participating in the Child Health Services (EPSDT) Program.

1. No prior authorization is required to obtain these services for beneficiaries under age twenty-one (21).
2. No benefit limits apply to orthotic appliances and prosthetic devices for beneficiaries under age twenty-one (21).

B. Arkansas Medicaid covers orthotic appliances for beneficiaries age twenty-one (21) and over. The following provisions must be met before services may be provided.

1. Prior authorization is required for orthotic appliances valued at or above the Medicaid maximum allowable reimbursement rate of $500.00 per item. Prior authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request.**
2. A benefit limit of $3,000 per state fiscal year (SFY; July 1 through June 30) has been established for reimbursement for orthotic appliances. No extension of benefits will be granted.

   The following restrictions apply to the coverage of orthotic appliances.:

   a. Orthotic appliances may not be replaced for twelve (12) months from the date of purchase. If a beneficiary's condition warrants a modification or replacement and the $3,000.00 SFY benefit limit has not been met, the provider may submit documentation to DHS or its designated vendor, to substantiate medical necessity. **View or print contact information for how to submit the request**.
   b. Custom-molded orthotic appliances are not covered for a diagnosis of carpal tunnel syndrome prior to surgery.

C. Arkansas Medicaid covers prosthetic devices for beneficiaries age twenty-one (21) and over; however, the following provisions must be met before services may be provided.

1. Prior authorization will be required for prosthetic device items valued at or in excess of the $1,000.00 per item Medicaid maximum allowable reimbursement rate. Prior

authorization may be requested by submitting form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor. **View or print form DMS-679A and instructions for completion.** **View or print contact information for how to submit the request**.

2. A benefit limit of $60,000 per SFY has been established for reimbursement for prosthetic devices. No extension of benefits will be granted.

3. The following restrictions apply to coverage of prosthetic devices:

   a. Prosthetic devices may be replaced only after five years have elapsed from their date of purchase. If the beneficiary's condition warrants a modification or replacement, and the $60,000 per SFY benefit limit has not been met, the provider may submit documentation to DHS or its designated vendor to substantiate medical necessity. **View or print contact information for how to submit the request**.

   b. Myoelectric prosthetic devices may be purchased only when needed to replace myoelectric devices received by beneficiaries who were under age twenty-one (21) when they received the original device.

D. The forms, listed below, are available for evaluating the need of beneficiaries age twenty-one (21) and over for orthotic appliances and prosthetic devices, and prescribing the needed appliances and equipment. The Medicaid Program does not require providers to use the forms, but the information the forms are designed to collect is required by Medicaid to process requests for prior authorization of orthotic appliances and prosthetic devices.

The appropriate forms (or the required information in a different format) must accompany the form DMS-679A. **View or print DMS-679A *titled Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* and instructions for completion.**

The forms and their titles are as follows:

1. DMS-647 Gait Analysis: Full Body. **View or print form DMS-647.**
2. DMS-648 Upper-Limb Prosthetic Evaluation. **View or print form DMS-648**.
3. DMS-649 Upper-Limb Prosthetic Prescription. **View or print form DMS-649**.
4. DMS-650 Lower-Limb Prosthetic Evaluation. **View or print form DMS-650**.
5. DMS-651 Lower-Limb Prosthetic Prescription. **View or print form DMS-651**.

212.700 Oxygen and Oxygen Supplies, All Ages 8-1-21

A prescription for oxygen must be accompanied by a current arterial blood gas (ABG) laboratory report from a certified laboratory or the beneficiary's attending physician. A current laboratory report is defined as one performed within a maximum of thirty (30) days prior to the prescription for oxygen.

A prescription for oxygen must specify the oxygen flow rate, frequency and duration of use, estimate of the period of need for oxygen and method of delivery of oxygen to the beneficiary (e.g., two liters per minute, ten (10) minutes per hour, by nasal cannula for a period of two months). A prescription containing only "oxygen PRN" is not sufficient.

The following medical criteria will be utilized in evaluating coverage of oxygen:

A. Chronic Respiratory Disease

1. Continuous oxygen therapy
   Resting Pa02 less than 55 mm Hg

2. Nocturnal oxygen therapy
   Resting Pa02 less than 60 mm Hg

3. Exercise oxygen therapy
   Pa02 with exercise less than 55 mm Hg

B. Congestive Heart Failure
   Symptomatic at rest, with Pa02 less than 60 mm Hg

C. Carcinoma of the Lung
   Resting Pa02 less than 60 mm Hg

D. Others
   Reviewed on an individual basis

E. Children
   O2 saturation below 94% by pulse oximeter with elevated PCO2 by capillary blood gas or end-tidal CO2 on two separate occasions.

The prior authorization request for all oxygen and respiratory equipment must be submitted on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* to DHS or its designated vendor for beneficiaries of all ages. **View or print form DMS-679A and instructions for completion. View or print contact information for how to submit the request**.

220.000 PRIOR AUTHORIZATION

221.000 Prosthetics Services Prior Authorization 4-1-09

Reimbursement for specified prosthetics services must be prior authorized. Prior authorization is required on items indicated (e.g., oxygen) or if the reimbursement for an item or items is $1000.00 or more (e.g., wheelchair and/or components).

221.100 Request for Prior Authorization 8-1-21

The request for prior authorization must originate with the prosthetics provider. The provider is responsible for obtaining the required medical information and prescription needed for completion of the prior authorization request form. **View or print contact information for how to submit the request**.

221.300 Approvals of Prior Authorization 8-1-21

A. DHS or its designated vendor reviews requests for prior authorization for wheelchair and wheelchair seating systems. If necessary, additional information shall be requested to determine the medical need. **View or print contact information for how to submit the request**.

1. When a request is approved for wheelchairs, wheelchair seating systems or wheelchair repair, a prior authorization control number will be assigned. Determination of “purchase,” “rental only,” or “capped rental” will be made and an expiration date for “rental only” and “capped rental” items will be assigned. This information will be indicated on the copy of the form DMS-679 that is returned to the provider within thirty (30) working days of receipt of the prior authorization request.

2. Prior authorization may only be approved for a maximum of six (6) months (180 days) for beneficiaries of all ages. Within thirty (30) working days before the end of currently prior authorized prosthetics services, the prosthetics provider must obtain a new prescription. If applicable, the provider must prepare and send a new *Medical*

Equipment Request for Prior Authorization and Prescription Form (Form DMS-679), signed by the physician.

3. The effective date of the prior authorization will be the date on which the beneficiary's physician prescribed prosthetics services or the day following the last day of the previously prior authorized time period, whichever comes last.

B. Providers should note the following authorization process exception.

1. Prior authorization numbers for "capped rental" items will be effective for the entire "capped rental" time period of fifteen (15) months. Therefore, only one prior authorization number is needed.

a. Providers may use the one (1) prior authorization number for billing of "capped rental" items for all fifteen (15) months.

b. Previous prior authorization for an item will count toward the total 15-month period.

c. Providers must resubmit a request for prior authorization after the first 180 days.

d. Necessary information will be indicated on the copy of the notification letter sent to the provider within thirty (30) working days of receipt of the prior authorization request.

221.400 Denial of Prior Authorization Request 6-1-25

For denied cases, both Utilization Review and AFMC will mail a letter containing case specific rationale that explains why the request was not approved to the requesting provider and to the Medicaid beneficiary within thirty (30) working days of receipt of the prior authorization request.

221.500 Administrative Reconsideration and Appeals 6-1-25

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

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

221.600 Reserved 6-1-25

230.000 REIMBURSEMENT

231.000 Prosthetics Service Method of Reimbursement 10-13-03

Reimbursement for prosthetics services is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum allowable.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time service is provided and upon accurate completeness of the claim filed for the service. The provider is responsible for verifying the beneficiary's eligibility by checking the beneficiary's eligibility through the system.

231.010 Fee Schedule 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.

232.000 Specialized Wheelchair, Seating and Rehabilitative Equipment Reimbursement for Repairs 2-1-22

Reimbursement for **repairs** of specialized wheelchairs will be the manufacturer's list price for parts listed less 40% manual equipment (dealer discount), 30% power equipment (dealer discount), plus 35% (profit margin), plus labor billed by the unit (15 min. = 1 unit). A maximum of twenty (20) units (20 units = 5 hours of labor) per date of service is allowable. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to the claim form.

Reimbursement for specialized wheelchair equipment, seating and rehab items requiring manual pricing is calculated using the manufacturer's current published suggested retail price less 15%. Any applicable pages from the manufacturer's catalog that reflect a description and the manufacturer's current published suggested retail price must be attached to the claim.

Kaye Products will be reimbursed at a set rate; therefore, the Kaye Products (procedure codes, modifiers **EP**, **U1**;, modifiers **EP**, **U3**; and, modifiers **EP**, **U4**) may be billed electronically.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

233.000 Orthotic and Prosthetic Reimbursement for Repairs 2-1-22

Providers must bill for the repair of orthotic appliances and prosthetic devices utilizing the procedure codes listed in the table below. One unit of service equals 15 minutes. A maximum of 20 units of service is allowed per date of service. Any applicable pages from the manufacturer's catalog and the manufacturer's invoice for parts must be attached to all repair claims.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Reimbursement for orthotic appliances and prosthetic devices requiring **manual pricing** will be calculated using the manufacturer's invoice price plus 10%. The manufacturer invoice must be attached to all repair claims.

234.000 Durable Medical Equipment (DME) Reimbursement for Repairs 8-1-05

Reimbursement for **repairs** of durable medical equipment (DME) will be manufacturer's invoice price for parts plus 10% and labor billed per unit (15 minutes = 1 unit of service). A maximum of twenty (20) units (20 units = 5 hours of labor) per date of service is allowable. The manufacturer's invoice must be attached to the repair claim for all parts.

Reimbursement for unlisted DME requiring **manual pricing** will be calculated using the manufacturer's invoice price plus 10%. The manufacturer's invoice must be attached to all repair claims.

235.000 Speech Generating Device Reimbursement for Repairs 1-1-21

Reimbursement for repairs of speech generating device components will be manufacturer's invoice price for parts plus 10%. Labor will be reimbursed per unit of service (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

236.000 Reimbursement for Repair of the Enteral Nutrition Pump 2-1-22

Reimbursement for repairs to the enteral nutrition infusion pump requires prior authorization. Repairs will be approved only on equipment purchased by Medicaid. Therefore, no repairs will be reimbursable prior to the equipment becoming the property of the Medicaid beneficiary.

Requests for prior authorization for enteral pump repairs must be submitted to DHS or its designated vendor. **View or print contact information for how to submit the request**. Requests must be made on form DMS-679A titled *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components.* (**View or print form DMS-679A and instructions for completion.**)

The repair invoice and the serial number of the equipment must accompany the prior authorization request form. Total repair costs to an infusion pump may not exceed $290.93. Medicaid will not reimburse for additional repairs to an infusion pump after the provider has billed repair invoices totaling $290.93. If the equipment is still not in working order after the provider has billed the Medicaid maximum allowed for repairs, the provider must supply the beneficiary with a new infusion pump and may bill either procedure code after receiving prior authorization for the new piece of equipment.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

237.000 Rate Appeal Process 8-1-05

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medial Services. The 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.

When the provider disagrees with the decision of the Assistant Director, Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review 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 chairperson.

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 panel will hear the question(s) and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Prosthetics 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.

242.000 CMS-1500 Billing Procedures

242.100 HCPCS Procedure Codes 11-1-17

242.105 Payment Methodology 8-1-05

Arkansas Medicaid has several methods of payment for all items covered by the Program. The following is a breakdown of the methods.

A. Purchase items are equipment that is purchased for or purchased by an eligible Medicaid beneficiary. The equipment may be new or used.

B. Rental-only items are those items paid by Arkansas Medicaid to providers for an unspecified time period on an as-needed basis. The equipment may be new or used.

C. A capped rental item is equipment whose purchase price exceeds $150.00. The items may be new or used. The items are reimbursed utilizing a daily rental rate. Medicaid pays the daily rental rate not to exceed a fifteen- (15-) month rental maximum (455 days). A period of continuous use allows for periods of interruption up to 60 consecutive days. If the interruption is 60 or fewer consecutive days, a new 15-month rental period will not begin. If the interruption is more than 60 days, a new 15-month rental period will begin.

D. After the total cost of a capped rental item has been reimbursed by Medicaid, the item remains the property of the DME provider. For items that have reached a 15-month rental cap, claims will be paid for maintenance and servicing fees after six months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later.

E. Providers may be reimbursed for capped rental and rental-only items if the equipment is used fewer than 30 consecutive days from the first day of rental. This ensure the provider of adequate reimbursement for equipment used fewer than 30 days.

F. A rent-to-purchase item is an item for which Arkansas Medicaid reimburses a provider for the Medicaid-established purchase price of the item. After reimbursement has reached the maximum allowed, the equipment will become the property of the Medicaid beneficiary. Reimbursement is only approved for new equipment.

G. Initial rental transactions are those for which equipment is used in a beneficiary's home for fewer than 30 consecutive days. Initial rental transactions must not be used by the provider to bill a month in advance. Arkansas Medicaid will only pay after services are rendered. An example of an initial rental transaction is that of a hospital bed delivered on July 2 and removed from the home after 10 days.

H. Manually priced items are those for which Arkansas Medicaid pays the manufacturer's invoice price plus 10 percent. The provider must attach the invoice with their claim for services rendered.

I. A used item is any item that has been rented for 90 days or longer by anyone prior to the current Medicaid "rental only" or capped rental" transaction. The provider must maintain

documentation that certifies a used item is reconditioned and in good working order and has no defect in workmanship or material.

J. Repair of a "rental only" item is covered in the rental fee. Repair of "purchased" items is covered separately. Total (cumulative) repair costs must not exceed 50% of the item's total purchase cost.

242.110 Respiratory and Diabetic Equipment, All Ages 2-1-22

When billed either electronically or on paper, procedure codes found in this section must be billed with certain modifiers. Modifiers in the section are indicated by the headings M1 and M2. When only the **NU** modifier is shown in the M1 column, the procedure code may be billed for beneficiaries of all ages. When **NU** and **EP** are listed together in the M1 column, the NU modifier must be used when billing for beneficiaries age 21 and over, and the EP modifier must be used when billing for beneficiaries under age 21. When a modifier is listed in the M2 heading, that modifier must be used in conjunction with either **NU** or **EP**.

Prior authorization requirements are shown under the heading PA. If prior authorization is needed, the information is indicated with a "Y" in the column; if not, an "N" is shown.

♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.111 Initial Rental of a DME Item for Individuals of All Ages 2-1-22

Procedure codes found in this section may be billed either electronically or on paper.

Some procedure codes have been assigned a modifier that affects the billing process. Required modifiers are indicated in the M1 column in the list below. When a modifier is shown in the M1 column, it must be listed along with the procedure code when requesting payment by Arkansas Medicaid.

Procedure codes shown in the list below are either covered for all ages (AA), only for individuals under age 21 (U21) or only for individuals age 21 and over (21+). A column in the list below defines the differences.

♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Providers will be reimbursed for a minimum of 30 days of rental when the equipment is used less than 30 days. Initial rental codes must be billed when equipment is used less than 30 days during the first month of rental.

Arkansas Medicaid will only reimburse for one initial minimum 30 days of rental per state fiscal year period per beneficiary per procedure code. The provider will not be reimbursed for the same procedure code utilizing another modifier for the same time period.

242.120 Medical Supplies for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper using modifier **NU** for beneficiaries of all ages. When a second modifier is listed, that modifier must be used in conjunction with the modifier **NU**.

Modifiers in this section are indicated by the headings M1 and M2

1 Not all medical supplies require prior authorization. Supplies with this symbol require prior authorization. Form DMS-679A must be used to request prior authorization. Note: Compression burn garments are manually priced. The manufacturer's invoice must be submitted with the request for compression burn garments. **View or print form DMS-679A and instructions for completion.**

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.121 Food Thickeners, All Ages 2-1-22

Food thickeners, including "Thick-It," "Thick-It II," "Simply Thick," "Thick and Easy" and "Thick and Clear" are not subject to the $250 medical supply benefit limit.

The modifier **NU** must be used with the procedure code found in this section and when food thickeners are to be administered enterally, the modifier "**BA**" must be used in conjunction with the procedure code.

When food thickeners are billed, total units are to be calculated to the nearest full ounce. Partial units may not be rounded up. When a date span is billed, the product cannot be billed until the end date has elapsed.

The maximum number of units allowed for food thickeners is 16 units per date of service.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.122 Jobst Stocking for Beneficiaries of All Ages 2-1-22

The gradient compression stocking (Jobst) is payable for beneficiaries of all ages. However, before supplying the item, the Jobst stocking must be prior authorized by DHS or its designated vendor. **View or print contact information for how to submit the request.** Documentation accompanying form DMS-679A must indicate that the beneficiary has severe varicose veins with edema, or a venous stasis ulcer, unresponsive to conventional therapy such as wrappings, over-the-counter stockings and Unna boots. The documentation must include clinical medical records from a physician detailing the failure of conventional therapy. **View or print form DMS-679A and instructions for completion.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.123 Negative Pressure Wound Therapy Pump Accessories and Supplies for Beneficiaries Ages 2 Years and Older 2-1-22

Effective for dates of service on or after May 11, 2012, procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries aged 2-20 years or modifier **NU** for beneficiaries aged 21 and over.

Modifiers in this section are indicated by the heading M1. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.130 Diapers and Underpads for Beneficiaries Ages 3 Years and Older 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization is indicated by the heading PA. If prior authorization is required, that information is indicated with a "Y" in the column, or if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Reimbursement is based on a per unit basis with one unit equaling one item (diaper, underpad). When billing for these services that are benefit limited to a dollar amount per month, providers must bill according to the calendar month.

Providers must not span calendar months when billing for diapers and/or underpads. The date of delivery is the date of service. Providers should not bill "from" and "through" dates of service.

Refer to Section 212.100 of this manual for coverage information on diapers and underpads.

242.140 Electronic Blood Pressure Monitor and Cuff, All Ages 2-1-22

The procedure code found in this section must be billed either electronically or on paper using modifier **NU** for individuals of all ages.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

- ♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Included with the rental of this monitor, the provider will need to supply one (1) disposable blood pressure cuff each month.

242.150 Nutritional Formulae for Child Health Services (EPSDT) Beneficiaries Under Twenty-one (21) Years of Age 2-1-22

The following list provides the enteral formula HCPCS procedure codes, any associated modifiers, code descriptions, and the formula covered for each HCPCS code. The code description lists the formula included in the category of nutrients.

The coverage listed is payable only if the service is prescribed as a result of a Child Health Services (EPSDT) screening/referral.

No prior authorization is required for nutritional formulae for EPSDT beneficiaries from age five (5) years through twenty (20) years.

Prior authorization is required for beneficiaries from birth through four (4) years. Use of modifier **U7** in the following list will be necessary, as indicated.

To request prior authorization, providers should complete the *Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components* (DMS-679A), attaching a copy of the EPSDT screening/referral as well as a prescription signed by the beneficiary's PCP. **View or print form DMS-679A**. **View or print contact information for how to submit the request.**

NOTE: The Women, Infant, and Children program (WIC) must be accessed before the Medicaid program for children from birth to five (5) years of age.

The Arkansas Medicaid program mirrors coverage of approved WIC nutritional formulae. As stated in current policy, the WIC Program must be accessed first for Arkansas Medicaid beneficiaries aged zero (0) to five (5) years, prior to requesting supplemental amounts of WIC-approved nutritional formula. The Medicaid nutritional formula list will be updated accordingly to continue compliance with the WIC Program in Arkansas. Changes will be reflected in the appropriate Medicaid provider manual.

For beneficiaries from birth through four (4) years of age, the use of modifier **U8,** as well as additional documentation, will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

An EPSDT screening, which documents the PCP's medical rationale for prescribing a formula, as well as medical records documenting the beneficiary's failed trials of WIC formula, must be submitted for review. Flavor preferences for formulae will not be considered for medical necessity.

Exceptions to Use of Formulae

The following exceptions must be followed in order to use formulae listed in this section.

A. Nutramigen LIPIL – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

B. Nutramigen Enflora LGG – Sensitivity or allergy to milk or soy protein; chronic diarrhea, food allergies, GI bleeds. Similac Advance must first have been tried.

C. Pregestimil – Allergy to milk or soy protein; chronic diarrhea, short gut; cystic fibrosis; fat malabsorption due to GI or liver disease.

D. Gerber Extensive HA – Allergy to milk or soy protein; severe malnutrition; chronic diarrhea; short bowel syndrome; known or suspected corn allergy. Similac Advance must first have been tried.

E. Alfamino Junior – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Neocate Junior with Prebiotics is intended for children over the age of one (1) year.

F. Alfamino Infant – Allergy to cow's milk, multiple food protein intolerance, and food allergy associated conditions: short bowel syndrome, gastroesophageal reflux disease (GERD), eosinophilic esophagitis, malabsorption, and other GI disorders. Similac Expert Care Alimentum, Nutramigen, or Pregestimil must first have been tried.

G. Portagen – Pancreatic insufficiency, bile acid deficiency, or lymphatic anomalies; biliary atresia; liver disease; chylothorax.

H. Similac PM 60/40 – Renal, cardiac, or other condition that requires lowered minerals.

I. Periflex Infant – PKU; Hyperphenylalaninemia; for infants and toddlers.

J. PKU Periflex Junior Plus – Hyperphenylalaninemia; for children and adults.

K. Gerber Good Start Premature 24– Preterm, low birth weight. Not intended for feeding low birth weight infants after they reach a weight of 3600 g (approximately eight (8) lbs.). Not approved for an infant previously on term formula or a term infant for increased calories.

L. Enfamil EnfaCare – Preterm infant transitional formula for use between premature formula and term formula. Not approved for an infant previously on term formula or a term infant for increased calories.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. Modifier **BO** is used to bill for oral usage. When a second or third modifier is listed, that modifier must be used in conjunction with **EP**.

For beneficiaries from birth through four (4) years of age, the use of modifier **U7,** as well as additional documentation will be required when a non-WIC formula is prescribed, or WIC guidelines are not followed when prescribing special formula.

Modifiers in this section are indicated by the headings M1, M2, M3 and M4.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

One (1) unit of service equals one-hundred (100) calories with a reimbursable maximum of thirty (30) units per day. Supplies furnished by prosthetics providers in conjunction with the nutritional formula must be billed to Medicaid with the prosthetics medical supply codes. These formulae are covered as nutritional supplements rather than as the sole source of nutrition.

NOTE: Beneficiaries who require enteral nutrition as the sole source of nutrition with the formulae being administered through a nasogastric, jejunostomy or gastrostomy tube should be referred to a hyperalimentation provider enrolled in the Medicaid Program.

Each claim should reflect a "from" and "through" date of service. The claims must not be filed until after the "through" date has elapsed. Claims may be submitted on either a weekly or a monthly basis.

242.151 Pedia-Pop 2-1-22

The procedure code found in this section must be billed with modifier **EP**. Pedia-Pop is only for oral consumption, and is only in frozen form.

Modifiers in this section are indicated by the headings M1 and M2.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.152 Enteral Nutrition Infusion Pump and Enteral Feeding Pump Supply Kit 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under twenty-one (21) years of age. When a second modifier is listed, that modifier must be used in conjunction with **EP**.

The procedure codes require prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Enteral Nutrition Infusion Pump

Reimbursement for the enteral nutrition infusion pump is based on a rent-to-purchase methodology. Each unit reimbursed by Medicaid will apply towards the purchase price established by Medicaid.

Reimbursement will only be approved for new equipment. Used equipment will not be prior authorized. Procedure codes represent a new piece of equipment being reimbursed by Medicaid on the rent-to-purchase plan.

Codes are reimbursed on a per unit basis with 1 day equaling 1 unit of service per day.

Medicaid will reimburse on the rent-to-purchase plan for a total of 304 units of service. After reimbursement has been made for 304 units, the equipment will become the property of the Medicaid beneficiary.

Prior authorization is required for codes. The prior authorization request must include the serial number of the infusion pump being provided to the beneficiary.

See Section 236.000 for reimbursement when the Medicaid Program is billed for repairs made to the enteral infusion pump.

242.153 Low-Profile Skin Level Gastrostomy Tube (Low-Profile Button) and Low-Profile Percutaneous Cecostomy Tube and Supplies for Beneficiaries of All Ages 2-1-22

NOTE: When billing for the Low-Profile Percutaneous Cecostomy Tube or supplies, an additional third modifier UA will be required.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and service.

242.154 Nasogastric Tubing for Individuals Under Age 21 2-1-22

The procedure code found in this section must be billed with modifier **EP** for beneficiaries under 21 years of age. The code is payable only for beneficiaries under age 21.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.155 Billing and Reimbursement Protocol for FM (Frequency Modulation) System and Replacement Cochlear Implant Parts 2-1-22

Procedure codes in the table below require paper claim submission 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. Procedure codes may be submitted electronically or on a paper claim form. Procedure code may be submitted electronically or on a paper claim form. For provider charges for an FM system that is meant to be used with a cochlear implant, should reflect the retail price. For reimbursement of an FM system to be used with a cochlear implant, will be at 68 percent of the retail price.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

*Denotes paper claim

242.160 Durable Medical Equipment, All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**. Modifier **UE** is required when billing for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

*	The purchase of wheelchairs for individuals age 21 and older is limited to one per five-year period.
***	This procedure code may not be billed for used equipment.
♦	Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.
**(…)	This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.
3	This item is a capped rental for 90 days only, and requires PA and a review.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Procedure codes must be billed when hospital beds are purchased for Medicaid beneficiaries of all ages. Providers must only provide these purchase-only services to beneficiaries who are expected to require the bed for a long period of time. **Each procedure code for hospital beds listed above may only be billed once every 10 years.**

Procedure codes must also be used to bill for equipment that does not meet the purchase-only criteria. They are reimbursed on a capped rental basis. The capped rental items must be used until the equipment is no longer repairable or until it is no longer appropriate for the beneficiary as verified by the physician.

242.161 Reserved 1-1-10

242.170 Apnea Monitors for Beneficiaries Under 1 Year of Age 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age. Modifier **UE** must be used to bill for used equipment.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Sections 212.300 and 222.200 contain information regarding specific coverage and restrictions.

- ♦ Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.
- ⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.180 Orthotic Appliances for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for individuals age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown. When prior authorization is not applicable (for U21) that information is shown with an "N/A" in the column.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for individuals under age 21 and "21+" is shown when the code is payable only for those individuals age 21 and older.

- ** This item is not a covered service for the diagnosis of Carpal Tunnel Syndrome prior to surgery.
- ⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.
- ■ This procedure code does not require prior authorization; however, the beneficiary's medical condition must fall within the following diagnosis codes. **(View ICD codes.)**
- + This item is limited to one every twelve months for beneficiaries age 21 and over.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.190 Prosthetic Devices for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed for beneficiaries age 21 and older, that information is indicated with a "Y" in the column; if not, an "N" is shown.

When codes are payable for all ages, "All" is indicated in the column, "U21" is shown when the code is payable only for beneficiaries under age 21 and "21+" is shown when the code is payable only for those beneficiaries age 21 and older.

[1] The purchase of this component is limited to one per five-year period for beneficiaries age 21 and over.

* Replacement only

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.

NOTE: Procedure codes for prosthetic eyes and information regarding prosthetic eye care is located in the Arkansas Medicaid Visual Care Program Manual.

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.191 Specialized Wheelchairs and Wheelchair Seating Systems for Individuals Age Two Through Adult 2-1-22

Arkansas Medicaid covers wheelchairs and wheelchair seating systems for individuals ages two through adult.

For any item to be covered by Arkansas Medicaid, the beneficiary must be eligible for a defined Medicaid Aid Category. Coverage is subject to the requirement that the equipment must be medically necessary for the diagnosis or treatment of an illness or injury to improve the functioning of an affected body part, and must meet all other Medicaid statutory and regulatory requirements and established criteria.

The beneficiary's diagnosis must warrant the type of equipment being purchased. Items may not be covered in every instance.

Providers are cautioned that an approved prior authorization does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and the provider at the time service is provided and submission of an accurate and complete request. The DME provider is responsible for verifying the eligibility of the beneficiary at the time service is provided.

Specialized wheelchairs and wheelchair seating systems must be ordered by a physician.

For those services that are not included in the Arkansas Medicaid State Plan, (e.g., highly technological wheelchairs and rehab equipment), the PCP must complete form DMS-693, titled Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral for Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan. **View or print form DMS-679 and instructions for completion.**

NOTE: If the service or item(s) are specifically included in the Arkansas Medicaid State Plan, the completion of form DMS-693 is not required.

When a request is submitted for a power wheelchair, Power-Operated Vehicle (POV) or specialized manual wheelchair, the following Medicaid requirements must be met:

A. A Prescription & Prior Authorization Request for Medical Equipment form (DMS-679) must be completed and submitted. This form must not be altered by the provider. **View or print form DMS-679 and instructions for completion.**

B. The DMS-679 must be signed and dated by the beneficiary's PCP, APRN or the ordering physician. The signature must be original. Stamp signatures are not acceptable. Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

C. Correct Medicaid procedure codes and modifiers must be utilized. Requested items will be denied if correct procedures codes and modifiers are not used.

D. All requests for prior authorization must be legible (felt pens must not be used).

E. Medicaid requires the submission of the original request.

F. Medical documentation from the beneficiary's PCP, APRN or ordering physician which included a detailed face-to-face medical examination must be submitted to establish medical necessity.

G. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. This evaluation will be completed in three parts:

1. Part A—to be completed by the DME provider.
2. Part B—to be completed by the assistive technology practitioner or can be completed by a physical therapist or occupational therapist or seating specialist for Group 1 (one) and Group 2 (two) power wheelchairs with no power options.
3. Part C—to be completed by the beneficiary's PCP, APRN or the ordering physician.
4. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be completed for all specialized wheelchairs except for rental wheelchairs. **View or print form DMS-0843 and instructions for completion.**

H. A manufacturer's order form documenting the suggested retail price for the brand and model wheelchair and accessories and a manufacturer's quote must be submitted with the DMS 679.

I. A DMS-693, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) form, must be submitted for all pediatric wheelchairs and include detailed PCP or APRN medical documentation that clearly demonstrates medical necessity and clearly identifies the medical condition and the specific equipment that will meet the beneficiary's medical needs. Form DMS-693 and the supporting documentation must be submitted as an attachment to the request for prior authorization. It will then be reviewed for medical necessity. **View or print form DMS-693.**

J. If requirements A through I are not completed correctly, the request could be denied.

K. Arkansas Medicaid requires a Durable Medical Equipment (DME) provider to employ a RESNA (Rehabilitation Engineering and Assistive Technology Society of North America) certified ATP (Assistive Technology Practitioner) who specializes in wheelchair seating. The ATP will provide direct in-person recommendations for evaluation of the beneficiary's wheelchair selection, and is employed by the supplier. This applies for specialized manual wheelchair and power wheelchair in the category of Group 2 (single power option) and above.

The ATP's involvement in the wheelchair selection must be documented. Documentation of the ATP's involvement does not qualify as a face-to-face examination and may not be cosigned by a physician.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and older. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

Other coding information found in the chart:

[1] **The purchase of this component for beneficiaries age 21 and older is limited to one per five-year period.**

[2] **The purchase of this wheelchair component for beneficiaries under age 21 is limited to one per two-year period.**

* **The purchase of wheelchairs for beneficiaries age 21 and older is limited to one per five-year period.**

** **Bill only for beneficiaries under age 21.**

\# **This procedure code is payable for beneficiaries ages 2 through 20. Prior authorization is required through Utilization Review.**

**** **Items listed require prior authorization (PA) when used in combination with other items listed and the total combined value exceeds the $1,000.00 Medicaid maximum allowable reimbursement limit.**

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

Note: W/C or w/c indicates wheelchair.

⁂**(…)** **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Required Documentation

Face-to-Face Examination

In order for Medicaid to provide reimbursement for a Power/motorized Wheelchair (PWC), Power Operated Vehicle (POV) (scooter) or specialized manual wheelchair, the following requirements must be met.

A. A face-to-face physician examination must be performed.

B. The physician must perform a medical examination for the specific purpose of assessing the beneficiary's mobility limitation and needs. The results of this exam must be recorded in the patient's medical record.

C. The prescription must be written only **after** the face-to-face physician examination and assessment of mobility limitations have occurred and the medical history and physical examination is completed.

D. The prescription and the medical records documenting the in-person visit and examination report must be sent to the equipment supplier within forty-five (45) days of completion of the examination.

E. The physician may refer the beneficiary to a licensed/certified professional, a Physical Therapist (PT) or Occupational Therapist (OT) to perform a wheelchair assessment.

If the beneficiary is referred to a physical/occupational therapist before the physician completes the face-to-face examination, the physician must review the physical/occupational therapist's written report and perform the final examination. The forty-five (45)-day period begins on the date of the physician's final face-to-face examination and must be submitted with the prior authorization request.

The face-to-face examination must include:

A. History of the present condition(s) and past medical history that is relevant to mobility needs:

1. Symptoms that limit ambulation.
2. Diagnoses that are responsible for these symptoms.
3. Medications or other treatment for these symptoms.
4. Progression of ambulation difficulty over time.
5. Other diagnoses that may relate to ambulatory problems.
6. How far the patient can walk without stopping.
7. What ambulatory assistance (cane, walker, wheelchair, caregiver) is currently being used.
8. What has changed to now require use of a power mobility device.
9. Ability to stand up from a seated position without assistance.

B. Physical examination that is relevant to mobility needs:

1. Beneficiary's weight and height.
2. Cardiopulmonary examination.
3. Musculoskeletal examination, arm and leg strength and range of motion.
4. Neurological examination, gait, balance and coordination.

The examination should be tailored to the individual patient's condition. The history should clearly establish the patient's functional abilities and limitations related to mobility and ambulation.

In addition to all other requirements, a power mobility device is covered by Medicaid **only** if the beneficiary has a mobility limitation that significantly impairs his/her ability to perform activities of daily living within the home.

Provider-created forms and letters are not a substitute for other required forms and will not be considered.

Additional Wheelchair Documentation

A. The purchase of a wheelchair for individuals twenty-one (21) years of age and over is limited to one wheelchair per five (5)-year period if medically necessary. A wheelchair is a dependable mobility base with positioning components. It has complex positioning capabilities and is designed to grow in width, depth and height to accommodate physical changes of its users, it is of use to people with certain medical conditions and serves a specific medical purpose related to the condition of the patient.

B. The purchase of a wheelchair for an individual twenty (20) years of age and under is limited to one per two (2)-year period, if medically necessary.

C. Payment is made for one wheelchair only as stipulated in A. and B. Backup and loaner D. wheelchairs are not covered by Arkansas Medicaid.

D. Requests for a wheelchair that is beneficial primarily in allowing the beneficiary to perform leisure or recreational activities only will be denied. It is not medical in nature. Wheelchairs are authorized for medical use only.

E. Strollers and stroller-like chairs of any kind are not covered by Arkansas Medicaid. A stroller is a four-wheeled, often collapsible, chair-like carriage. They are helpful to caregivers and are typically used for transportation. Although stroller and stroller-like chairs may be used to transport individuals with medical conditions, such items do not serve a medical purpose. Strollers and stroller-like chairs have no positioning components for medical use, cannot be modified for growth and accommodate changes in medical or physical condition, and cannot be self-propelled by the individual.

F. Prior authorization is required even when insurance pays primary to Medicaid. Explanation of benefits (EOB) of the other insurance must be submitted with the request.

G. All wheelchair requests require a manufacturer's brand and the model name of the base.

H. In the event a wheelchair is stolen, damaged in the home, or by vehicle or fire, a police/fire report, copy of the home owners/auto insurance coverage and detailed documentation of events leading to the loss/damage are required.

I. Mobility bases for car seats are not covered by Medicaid.

J. Options, accessories, and replacement parts that are medically necessary for wheelchairs that do not have specific HCPCS codes should be coded (other accessories). The manufacturer's suggested retail price (MSRP) must be listed for each item coded, and the MSRP quote to the DME provider must be included. The MSRP quote must not be altered by the DME provider. If the MSRP is altered in any way, the request will be denied.

K. In the event a beneficiary wishes to change services from one DME provider to another DME provider, an affidavit signed and dated by the beneficiary must be submitted with the request from the new DME provider.

L. The existence of a procedure code does not necessarily indicate coverage by Arkansas Medicaid.

M. The allowed amount of a POV includes all options and accessories that are provided at the time of initial issue. This includes but is not limited to batteries, battery chargers, seating systems, etc. All options and accessories provided at the initial issue of a Power-Operated Vehicle (POV) are included and should not be billed separately.

N. If coverage criteria is not met for a specific item requested, and Arkansas Medicaid determines that another item is more appropriate and meets medical necessity, that item will be authorized.

O. The wheelchair will significantly improve the beneficiary's ability to participate in Mobility Related Activities of Daily Living (MRADL) and the individual will use the wheelchair on a regular basis in the home.

P. The individual's home will provide adequate access between rooms, maneuvering space and surface for use of the requested wheelchair.

Non-Covered Items for Specialized Wheelchairs and Wheelchair Systems

A. Items that are deluxe in nature. Deluxe items are items of convenience that are not medically necessary. Deluxe items are often used for social purposes or convenience. Deluxe items include deluxe accessories which increase the cost of purchase or operation. Deluxe items and deluxe accessories are not covered by Arkansas Medicaid.

B. Items for use in hospitals, nursing home or other institutions.

C. Items for the beneficiary's comfort or the caregiver's convenience.

D. Two pieces of equipment that serve the same purpose.

E. Backup and loaner wheelchairs.

F. Wheelchairs that primarily allow the beneficiary to perform leisure or recreational activities.

G. Mobility bases for car seats.

H. Items that are not primarily used in the treatment of a disease, injury or illness.

I. Any items or item upgrades that add cost without improving the beneficiary's ability to perform Mobility Related Activities of Daily Living.

Warranty, Maintenance and Replacement of Specialized Wheelchairs and Wheelchair Systems

All standard durable medical equipment must have a manufacturer's warranty. If a DME provider supplies equipment that is not covered under a warranty, the provider is responsible for repairs, adjustments, replacements and maintenance. The warranty begins on the date of delivery (date of service) to the beneficiary. The DME provider must keep a copy of the warranty for audit review by Medicaid. Medicaid may request a copy of the warranty.

DME suppliers must furnish at least a minimum of six (6) months warranty for any adjustments to new wheelchairs at no charge.

Labor will not be covered for the initial chair and for parts and services that are under warranty.

242.192 Specialized Rehabilitative Equipment for Beneficiaries of All Ages 2-1-22

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

** **Indicates that providers may bill only for beneficiaries under age 21.**

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

242.193 Speech Generating Device for Beneficiaries of All Ages 2-1-22

The speech generating device must be billed using the procedure code assigned to each component. The specific components will be reimbursed, as needed, for the procedure codes listed below and will count toward the lifetime limit of $7,500 per beneficiary.

Procedure codes found in this section must be billed either electronically or on paper with modifier **EP** for beneficiaries under 21 years of age or modifier **NU** for beneficiaries age 21 and over. When a second modifier is listed, that modifier must be used in conjunction with either **EP** or **NU**.

Modifiers in this section are indicated by the headings M1 and M2. Prior authorization requirements are shown under the heading PA. If prior authorization is needed, that information is indicated with a "Y" in the column; if not, an "N" is shown.

NOTE: Attach a manufacturer's invoice to the claim and indicate the item or parts billed on the invoice. A description and the amount billed for each item must be attached to the claim. If more than one item is billed under a procedure code, the description and billed amount of each item must be listed separately under each procedure code and attached to the claim. The total billed for each procedure code should be reflected in field 24F.

♦ **Prior authorization is not required when other insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.**

⁂(…) **This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product. When using a procedure code with this symbol, the product must meet the indicated Arkansas Medicaid description.**

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

Note: When repair charges for both parts and labor of the SGD is provided and/or billed on the same date of service, only one detail (parts only or labor only) of procedure code may be billed per beneficiary per date of service. Information must be specified on the paper claim to clarify the charges billed by the provider. Parts and labor charges must be itemized by narrative and documentation.

A. The charge for parts must be clearly documented. A manufacturer's invoice for the parts must be attached.

B. The labor charge and the time represented by the labor charge must be clearly documented.

242.194 Replacement, Growth and Modification of Specialized Wheelchairs and Wheelchair Seating Systems 9-1-18

Arkansas Medicaid will cover replacement equipment as needed due to growth, normal wear and tear, theft, irreparable damage or loss not covered by insurance.

The following requirements must be met:

A. Detailed documentation from the beneficiary's PCP or ordering physician /APRN describing the significant changes in the beneficiary's condition that require growth/modification or replacement must be submitted.

B. The request must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment). **View or print form DMS-679 and instructions for completion.**

C. An Evaluation for Wheelchair and Wheelchair Seating form (DMS-0843) must be submitted. The evaluation must be signed and dated by the beneficiary's PCP/APRN or

ordering physician. The signature must be an original signature. A stamped signature will not be accepted by Arkansas Medicaid. An electronic signature will be accepted. **View or print form DMS-0843.**

D. A manufacturer's suggested retail price list and a manufacturer's quote must be submitted. A quote created by the DME provider will not be accepted.

E. Requests for replacement where malicious damage, neglect or misuse of the equipment may have occurred may be investigated by Arkansas Medicaid. Requests may be denied if such circumstances are confirmed.

F. If a wheelchair is stolen or damaged by vehicle, fire or in the home, the beneficiary must provide the following with the request:

1. A police or fire report.
2. Copy of the homeowner's or auto insurance coverage.
3. Detailed documentation of events leading to the loss and damage.

If Arkansas Medicaid denies a repair or replacement in a case of malicious damage or misuse, payment of repairs is the responsibility of the beneficiary or caregiver.

242.195 Repairs of Specialized Wheelchairs and Wheelchair Systems 2-1-22

A. Arkansas Medicaid will cover repairs for wheelchairs and wheelchair seating.

B. Repair services must receive prior authorization from DHS or its designated vendor. **View or print contact information for how to submit the request**.

C. Detailed documentation from the technician that supports the equipment or services being requested must be submitted. Documentation must include the following:

1. Date and place of purchase of the current chair.
2. Brand and model name of the base.
3. Brand and model name of parts and accessories needed for repairs.

D. Correct procedure codes per the current Medicaid policy must be used. See **Section 242.191**.

E. Requests for repairs must be submitted on form DMS-679 (Prescription & Prior Authorization Request for Medical Equipment) and must be signed and dated by the beneficiary's PCP or ordering physician. **View or print form DMS-679 and instructions for completion.**

F. Repairs for previously authorized wheelchairs that the beneficiary has outgrown will not be covered if a new chair has been authorized.

G. In the event a request is submitted for repairs for a wheelchair authorized by another state agency, documentation or a delivery ticket showing that the wheelchair was authorized by another state agency must be submitted with the request.

H. Arkansas Medicaid will not cover repairs/damage due to the following:

1. Neglect.
2. Misuse.
3. Abuse.
4. Improper installation or repair by the DME provider.

5. Use of parts or changes by the DME provider or the beneficiary not authorized by Arkansas Medicaid.

I. When a request is submitted for a new wheelchair with a statement that the previous wheelchair cannot be repaired, documentation from the manufacturer of the previous chair stating the reason why the previous wheelchair cannot be repaired must be included.

J. If the previous wheelchair cannot be repaired, several color photographs taken at different angles must be included with the new request.

Miscellaneous

A. Only a physician can order a wheelchair.

B. A physician's evaluation is valid for a period of six (6) months. After six (6) months, the beneficiary must be re-evaluated by the physician to determine medical necessity for continued need based upon changes in conditions and measurements.

A DME request is considered outdated by Medicaid when it is first presented to Medicaid more than ninety (90) days from the date it was written, signed and dated by the physician.

242.200 National Place of Service and Modifier Codes 7-1-07

Electronic and paper claims require the same national place of service (POS) code.

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Doctor's Office	11
Patient's Home	12
Day Care Facility	52
Night Care Facility	52
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99
Independent Laboratory	81
Ambulatory Surgical Center	24
Residential Treatment Center	56
Specialized Treatment Facility	56
Comprehensive Outpatient Rehabilitative Facility	62
Independent Kidney Disease Treatment Center	65
Inpatient Psychiatric Facility	51
Modifiers	
EP-Service provided as part of EPSDT Program	

Place of Service	POS Codes
KH-Durable Medical Equipment (DME) item, initial claim, first month's rental	
NU-New Equipment	
RR-Durable Medical Equipment (DME) Rental	
U1-Medicaid Level of Care 1 (defined by state)	
U2-Medicaid level of Care 2 (defined by state)	
U3-Medicaid level of care 3 (defined by state)	
U4-Medicaid level of care 4 (defined by state)	
U5-Medicaid level of care 5 (defined by state)	
UE-Used durable medical equipment (DME)	
52-Reduced Services	

242.300 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.

242.310 Completion of CMS-1500 Claim Form 9-1-18

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).

Field Name and Number			Instructions for Completion
		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.
	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.

Field Name and Number	Instructions for Completion
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 codes 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.
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.

Field Name and Number	Instructions for Completion
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)/Advanced Practice Registered Nurse (APRN) referral is not required for prosthetics. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including 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.
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.

Field Name and Number	Instructions for Completion
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 International Classification of Diseases (ICD). List no more than 12 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 242.200 for codes.
C. EMG	Enter “Y” for “Yes” or leave blank if “No.” EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 242.100 through 242.195.
MODIFIER	Modifier(s) if applicable.

Field Name and Number		Instructions for Completion
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	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
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 N O.	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.
31.	SIGNATURE OF PHYSICIAN/ADVANCED PRACTICE REGISTERED NURSE 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.

Field Name and Number	Instructions for Completion
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.

242.400 Special Billing Procedures

242.401 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 Health Care 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**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.

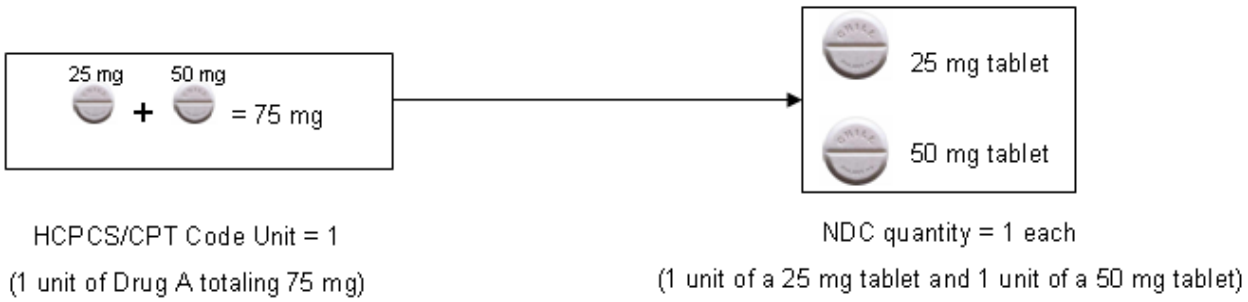
Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

I. Claims Filing

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

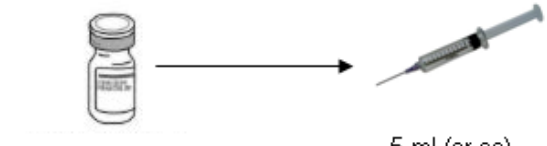
Example 1: The HCPCS/CPT code may specify up to 75 mg of the drug whereas the NDC quantity is typically billed in units, milliliters or grams. If the patient is provided 2 oral tablets, one at 25 mg and one at 50 mg, the HCPCS/CPT code unit would be 1 (1 total of 75 mg) in the example whereas the NDC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



HCPCS/CPT Code Unit = 1
(one 25 mg unit of Drug B)

NDC Quantity = 5 for the 5 ml administered

Waste = 5 ml or 25 mg
(for the 5 ml or 25 mg not administered)

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

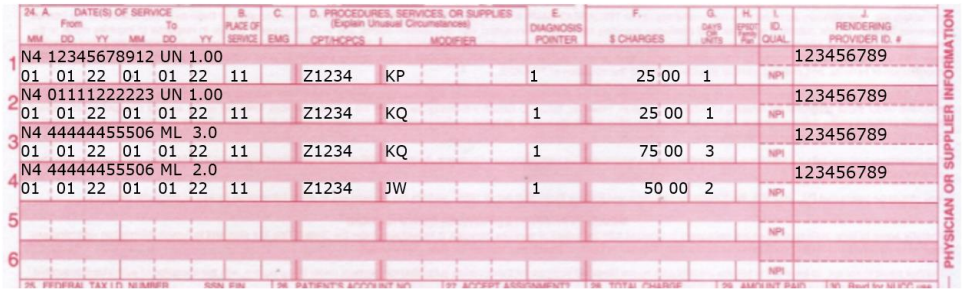
Providers are instructed to bill as follows:

- 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 modifier
- 3 NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- 4 or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

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.

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

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

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

View or print the procedure codes and modifiers for Durable Medical Equipment (DME), oxygen equipment and supplies, orthotic appliances, prosthetic devices and medical supplies, procedures and services.

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

1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.

2. **Multi-Use Vials**: Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.

3. **Documentation:** The provider must clearly document in the patient's medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

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

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

242.410 Completion of Form - Medicare/Medicaid Deductible And Coinsurance 10-13-03

If the Medicare fiscal intermediary is Arkansas Blue Cross/Blue Shield, the claim should be filed according to Medicare's instructions and sent to the Medicare intermediary. The Medicaid provider number and the beneficiary ID number must be entered in Field 9 on the claim form. The claim will automatically cross to Medicaid. If Medicaid reimbursement has not been received within six weeks after receiving Medicare payment, refer to Section 302.100.

242.420 Freight Charges, All Ages 10-13-03

Providers may include the freight charge on claims submitted to the Arkansas Medicaid Program for manual pricing and reimbursement of prosthetics services. If the freight charge is reflected as a charge on the manufacturer's invoice, this will provide necessary documentation. However, if there is a separate freight invoice, the freight invoice must also be attached to the claim.

When a provider has ordered several items and is submitting a claim to the Medicaid Program for only certain items included on the invoice, the provider must determine and indicate on the invoice, the freight charges for those items being billed to Medicaid. Only the freight charge incurred for the covered Medicaid items may be included on the Medicaid claim.