Housekeeping Rules for Attendees

All attendee microphones will remain muted throughout the webinar.

Please make sure you type your questions in the **Q&A** box.

Questions will be answered during the presentation.

To customize your presentation view, click the **Layout** button in the top right corner.

If you do not have the presentations, you can email mmisteam@afmc.org to request a link to access a copy.

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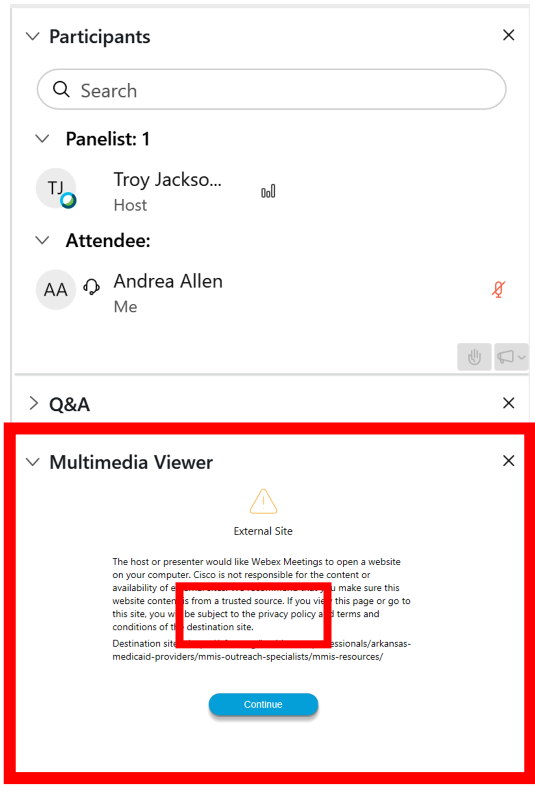
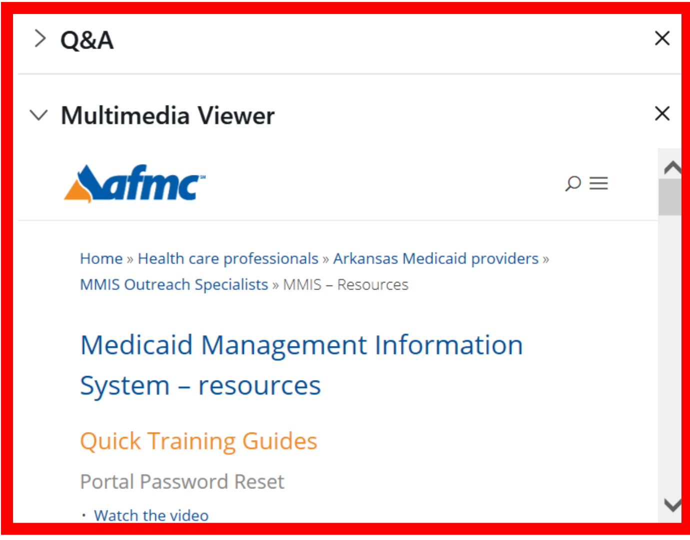
How to Access Training Materials During the Presentation

Open the Multimedia Viewer Panel and click "Continue."



You should see the AFMC MMIS webpage which will allow you to download the presentation and any additional training resources.



QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.

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Medicaid 101 Webinar Disclaimer

The Medicaid 101 Webinar is designed for ALL Provider types and specialties. We will only cover the items listed on the Agenda. In addition, we will not cover any specific provider types during this workshop. The Medicaid program has over 50 provider types. We invited all provider types to attend this webinar. Therefore, the information during this session will vary depending on the most relevant and immediate information.

If you have specific questions, technical issues or need Provider Enrollment, contact them at 1-800-457-4454. Please pay close attention to the options, as they have changed.

There are also job aids that will give you step-by-step instructions on: How to Check Eligibility, How to Check Status of a Claim, How to Submit and Review a Claim, How to Register for the Portal, and more. In addition, we now have Quick Track Training Videos to assist with Portal Password Reset, Eligibility Verification, Timely Filing, How to Adjust/Edit a Claim, How to Void a Claim, and Files Exchange for Health Care Innovation Documentation located on the DHS and AFMC websites.

If you have escalated issues or would like to discuss specific issues, please contact your AFMC MMIS Outreach Specialist at 501-906-7566 to set up a virtual or on-site visit. A map to contact your AFMC MMIS Outreach Specialist is located at afmc.org/mmis and the DHS/DMS website https://humanservices.arkansas.gov

For the latest information surrounding COVID-19 please visit the DHS websites at

Updates for Providers - Arkansas Department of Human Services

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Medicaid 101

Karen Young
Training and Program Developer, MMIS, AFMC

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MMIS Outreach Team

MMIS OUTREACH SPECIALISTS

HOURS OF OPERATION:
Monday–Friday • 8 A.M.–5 P.M.

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MMIS Outreach Team Map

MMIS Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • afmc.org/mmis

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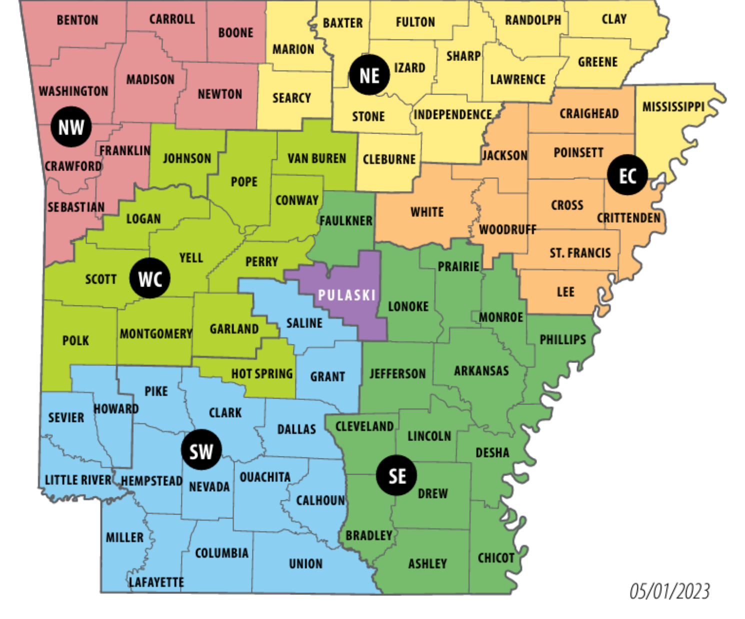
southwestbilling@afmc.org

Renee Smith
WC—West Central.....501-906-7566 Ext. 5-1
westcentralbilling@afmc.org



ARKANSAS DEPARTMENT OF HUMAN SERVICES, DMS

ARKIDS FIRST/MEDICAID
https://humanservices.arkansas.gov/
ARKids First Enrollment Information........................ 888-474-8275

CONNECTCARE
Toll free.................................... 800-275-1131

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)
Central Arkansas.............. 501-682-8349

ARKANSAS MEDICAID MANAGED CARE VOICE INFORMATION SERVICES
Toll free.............................. 800-805-1512

PHARMACY
Magellan Medicaid Administration
Help Desk 800-424-7895

TPL INFORMATION
Local 501-537-1070
Fax.. 501-682-1644
DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

GAINWELL TECHNOLOGIES *(Claims Processing)*

Gainwell Provider Assistance Center
In-state toll free 800-457-4454
Local and out-of-state 501-376-2211

Gainwell Provider Services Manager
Tyler Brickey............................ 501-590-6325

CLAIMS
P.O. Box 8034
Little Rock, AR 72203

SPECIAL CLAIMS
ATTN: Research Analysts
P.O. Box 8036
Little Rock, AR 72203

CROSSOVER CLAIMS
P.O. Box 34440
Little Rock, AR 72203

PROVIDER ENROLLMENT
P.O. Box 8105
Little Rock, AR 72203
Fax: 501-374-0746

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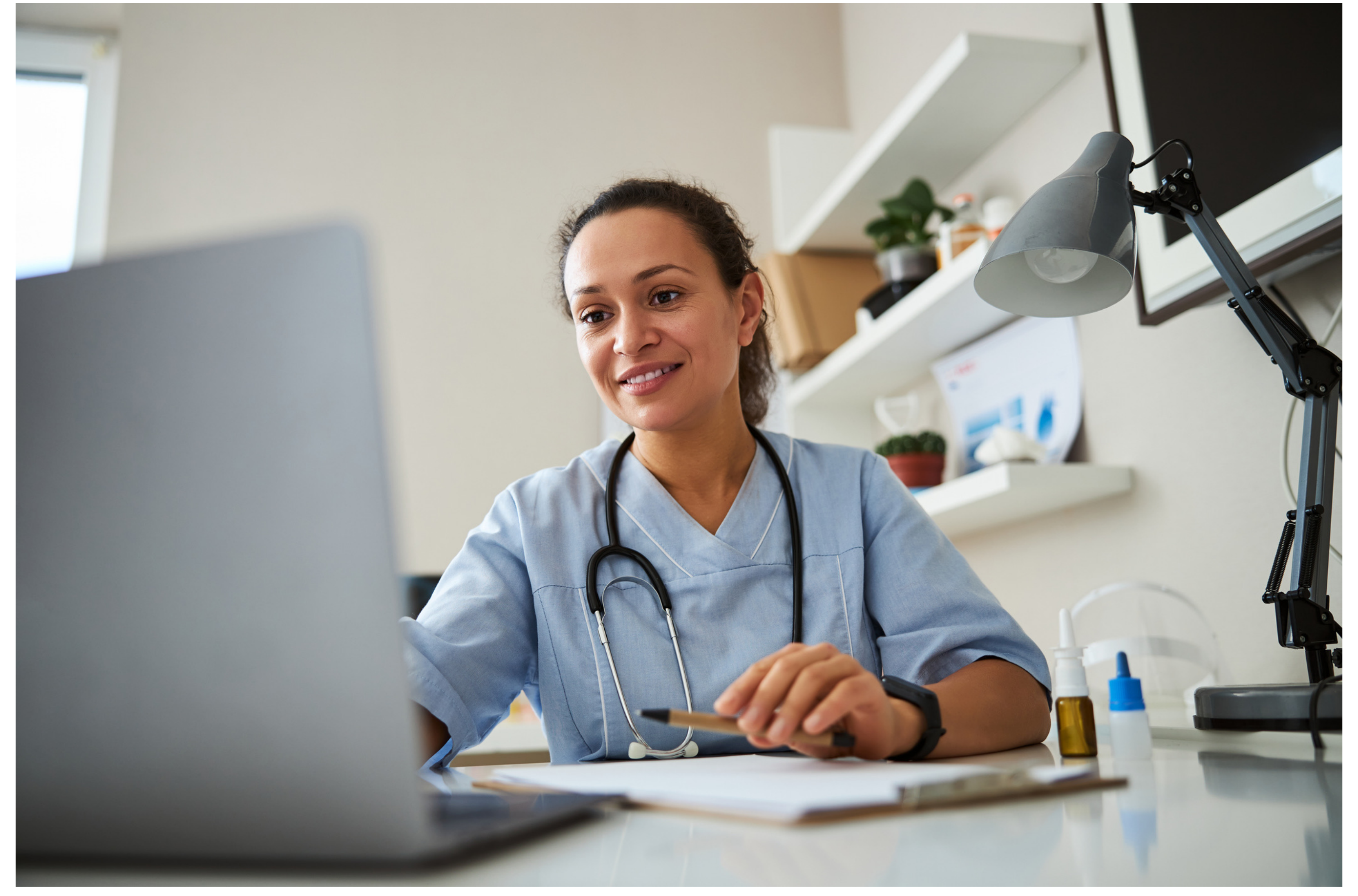
Agenda

- Provider Enrollment
- Provider Information
- Policy Manuals and Fee Schedules
- What is PERM?
- Prior Authorizations
- Healthcare Portal
- Things to Remember
- Medicaid Tools and Resources
- E-Blast Sign-Up Link
- Medicaid Contacts
- Evaluations
- Questions

Gainwell Technologies | Provider Enrollment



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Provider Enrollment

https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISIONS & SHARED SERVICES | NEWS | DATA & REPORTS | CAREERS | FIND A COUNTY OFFICE | FILE AN APPEAL | CONTACT US

Provider Enrollment

Divisions & Shared Services

Division of Medical Services

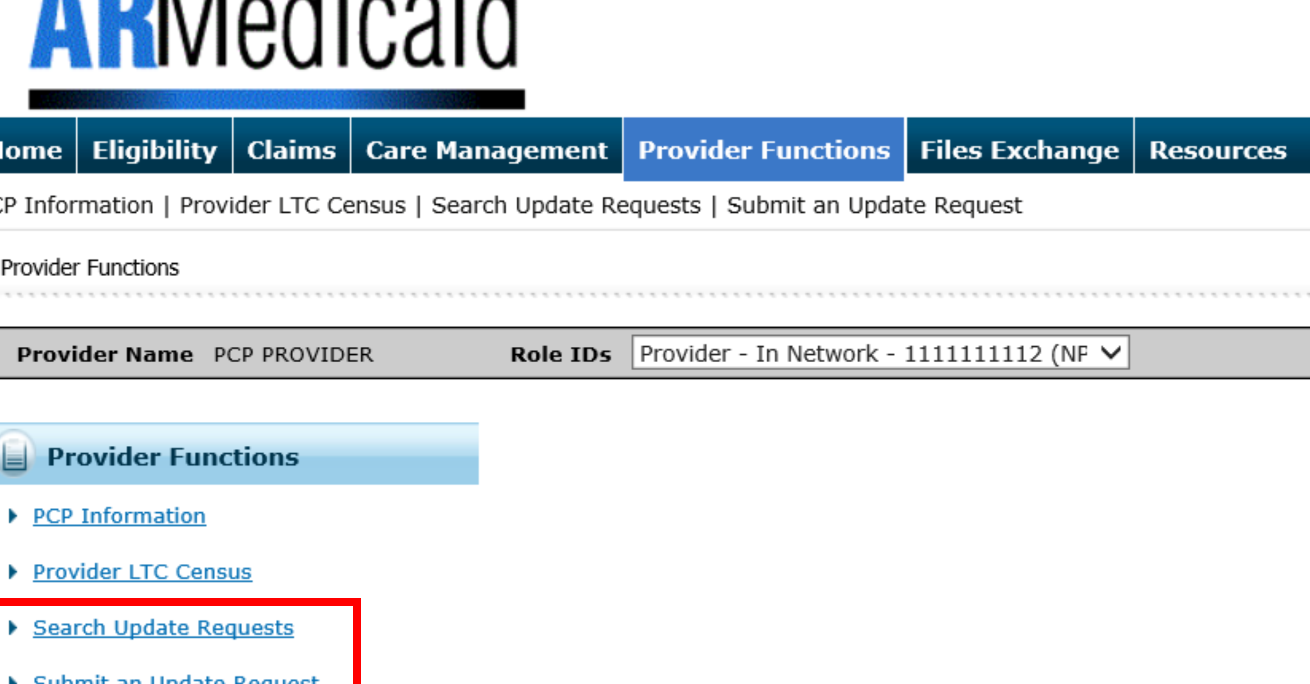
- Demonstration Waiver Projects

Home > Divisions & Shared Services > Division of Medical Services > Provider Enrollment

Provider Enrollment

Provider Re-validation on the Healthcare Portal

Provider Enrollment Updates



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Top 5 Reasons Update Requests Deny

EFT information

EFT form not being submitted with the voided check or bank letter. Voided Check not matching enrolling provider name.

Bank Letter not signed by the bank or the bank letter not listing the individual provider as having depositing rights if the account holder doesn’t match the enrolling provider. Request Types

Submitting a request under the incorrect request type. Listing incorrect Medicaid ID on documents or request ticket (Groups)

Groups submitting their individual provider updates not listing the correct Medicaid ID for each provider they are submitting the same request for. Missing Signatures Incomplete forms for requested change

Tips for Provider Enrollment per Gainwell

- Once enrolled you will receive a ***Welcome/Approval letter*** in the mail sent to the address on the application
- Once enrolled nothing else is needed from Provider Enrollment, until it is time for revalidation
- Revalidation occurs every 5 years excluding PT 95(revalidation not required for PT 95). You will be notified 90 days prior to your expiration date
- You can find enrollment forms for changes or updates here- Printable Enrollment-Related Forms
- Applications submitted on the portal can be checked for status or request for additional information for corrections
- If corrections are needed, click "resume enrollment" to access application and upload documentation
- Provider Enrollment enhancements on the Portal
- Remember the Update Request denial reasons to avoid any denials

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Provider Information

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Provider Information

- Nine-digit provider ID
- National provider ID (NPI)
- Atypical providers (NPI not required)
- Electronic Visit Verification (EVV)
- PASSE

Coordination of Benefits

"Medicaid beneficiaries are required to use third party sources of coverage that are available to them at no cost. By seeing an out-of-network provider, the Medicaid beneficiary was not using his or her available health care resources. Consistent with the general principle that Medicaid is the payer of last resort, Medicaid will not reimburse the provider or the beneficiary for any balance not paid by the commercial plan" (CMS, p.54, 2020).

If you provide services to a Medicaid eligible member but the services are denied by the member's primary insurance, you can use either a Certificate of Benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment) as proof the primary insurance was billed. Keep this in the client file for auditing purposes. The Certificate of Benefits or Denial EOB is good for one year.

Please note that it is the provider's responsibility to follow the billing policies of the liable third-party payer. Procedural denials from the liable third-party payer should be resolved prior to billing Medicaid. Failure to resolve procedural denials prior to billing Medicaid may result in delayed payments or denied claims. Additionally, the Medicaid filing deadline is not delayed while providers chase payment from potentially liable commercial third-party plans.

To show how this should be billed so the claim will bypass the TPL editing, the following example is provided.

The provider receives a denial letter from the insurance company(EOB with no payment to provider) dated 01/01/2019. The provider would say yes, primary insurance was billed using the denial date of 01/01/2019 and $0.00 payment amount in this example. Be sure to include the Claim Filing Indicator.

Reference: Centers for Medicare and Medicaid Services (CMS) (2020); Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid 2020; Retrieved 2/1/2024 URL: https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf

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TPL Documentation/Billing Guidelines

If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the member's primary insurance company, please see below for documentation and billing guidelines:

- A provider can use either a certificate of benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.
- It will be good for one year for either the Certificate of Benefits or Denial EOB.
- Example: Get certificate or denial dated 01/01/2024. The provider could use it through 12/31/2024. They would say "yes" they billed the insurance using a denial date of, in this example, 01/01/2024 and $0.00 payment amount. Be sure to include Claim Filing Indicator.

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Provider IDs | National Provider IDs

- Medicaid Provider ***9-Digit*** ID Number
  - Assigned by Arkansas Medicaid Provider Enrollment
  - Allows us to identify and verify valid Medicaid Providers

- National Provider ***10-Digit*** ID Number
  - Must be used when billing electronically(unless atypical or not required)
    - Some atypical providers are not required to bill with NPI
      - Bill with ***9-digit*** Provider ID number
    - NPI numbers are assigned by NPI registry
      - NPPES NPI Registry
      - https://npiregistry.cms.hhs.gov

Please note: *NPI Registry Public Search is a free directory of all active National Provider Identifier (NPI) records. Healthcare providers acquire their unique 10-digit NPIs*

What is Electronic Visit Verification (EVV)?

EVV is a process that uses electronic means to verify caregiver(s) visits when they are in the participant's home to provide care. This federal mandate is designed to enhance the quality and accuracy of services provided. Caregiver(s) are required to electronically record information about

- the types of services provided;
- the dates and times of the services;
- information about the person who is providing the services
- the clock in and clock out times for the visit.

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Electronic Visit Verification(EVV) Providers

- Please log in to the AuthentiCare system if you have not yet done so. If you have logged in, please begin, or continue to load required information into the system
- If you are using a third-party vendor, please ensure that your vendor has contacted Fiserv to test the aggregator or is currently testing
- If you have not received your credentials…You will receive credentials when training completion is confirmed, when your attestation form has been received by both you and your third-party vendor (if using third-party and not AuthentiCare), and when you have made any requested address change updates
- If you have **not yet completed all required training, please *immediately* contact**: evvarkansas@dhs.arkansas.gov
- All Arkansas Medicaid provider agencies must inform DHS of their decision by completing the Arkansas EVV Declaration Form. This form ***must be*** completed whether you choose to use AuthentiCare or a third-party system
- Please review the following DMS link as it has important information regarding what your first steps should be. Electronic Visit Verification (EVV) Information Webpage On DMS Website

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PASSE

Provider-Led Arkansas Shared Savings Entity

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What is a PASSE?

PASSE is a program that serves Medicaid clients with complex behavioral health, developmental, or intellectual disabilities. The goal of the PASSE system is to monitor client's health care needs, keep them healthy, and help them reach goals.

If the service(s) you provide are billed directly to the PASSE programs, it's **crucial** that you enroll with each PASSE.

A Medicaid client's services are managed and reimbursed by the PASSEs if the person:

- is on the Developmental Disabilities (DD) Waiver
- is on the DD Waiver wait list and gets Medicaid state plan services
- lives in a private DD Intermediate Care Facility
- has a Behavioral Health (BH) diagnosis and needs services in addition to counseling and medication management

Provider-led Arkansas Shared Savings Entity

What is a PASSE?

The PASSE model is a Medicaid-funded program that changes the way services are paid for by Medicaid for certain eligible individuals. It does not change a person's eligibility for Medicaid.

What services are covered?

The PASSE must make sure that a member has access to all services covered under the Medicaid State Plan, the Community Independence Waiver, and Community & Employment Supports Waiver, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children.

State Plan Services (most highly used, not a full list)

- Personal Care
- Primary Care Physician
- Durable Medical Equipment
- Occupational Therapy
- Speech Therapy
- Physician Specialists
- Pharmacy
- Hospital Services
- Physical Therapy
- Nursing Services
- Family Planning
- Inpatient Psychiatric
- Outpatient Behavioral
- Health Counseling

PASSE-Specific Home & Community Based Services

- Respite
- Supported Employment
- Supportive Living
- Supportive Housing
- Behavior Assistance
- Peer Support
- Family Support Partners
- Pharmaceutical Counseling
- Crisis Intervention
- Community Transition Services
- Supplemental Support
- Specialized Medical Supplies
- Adult Rehabilitation Day Treatment
- Child & Youth Support Services
- Supportive Life Skills Development
- Mobile Crisis Intervention
- Therapeutic Host Home
- Recovery Support Partners
- Adaptive Equipment
- Environmental Modifications
- Consultation
- Therapeutic Communities
- Partial Hospitalization
- Substance Abuse Detoxification
- Residential Community Reintegration

If a person is eligible to receive the services below, they will still be covered by Medicaid. However, these services will not be managed by the PASSEs.

- Non-Emergency Medical Transportation (NET)
- Dental benefits in a fixed payment program
- Services provided at school that are covered in an IEP

For more information, call 1-833-402-0672 110119

Sign up to receive important updates from DHS: Email Sign Up

PASSE Contact Information

- Arkansas Total Care
  P.O. Box 25010
  Little Rock, AR 72221
  1-866-282-6280
  arkansastotalcare.com
- CareSource
  Provider Services – 1-833-230-2005 (TDD/TTY 711)
  425 W. Capitol Ave Ste.3000 | Little Rock, AR 72201
  Provider Services 1.833.230.2100
  caresource.com/ar/plans/caresource-passe/
- Empower Healthcare Solutions
  1401 W. Capitol Avenue, Suite 430
  Little Rock, AR, 72201
  1-866-261-1286
  getempowerhealth.com
- Summit Community Care
  650 Shackleford R. #440
  Little Rock, AR 72211
  1-844-405-4295
  summitcommunitycare.com

Tips for Provider Information and Provider IDs

9-digit Medicaid Provider ID indicates the provider specialty/type,

10-digit NPI-always use when billing electronically if required to have NPI

EVV-Caregiver(s) are required to electronically record information

PASSE Services-If the service(s) you provide are billed directly to the PASSE programs, it’s **crucial** that you enroll with each PASSE.

Policy Manuals and Fee Schedule

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Provider Manuals

- Section I
  - General policy
  - General information, sources, client eligibility and responsibilities, provider participation, administrative (and non-compliance) remedies and sanctions, PCP case management program, and required services and activities
- Section II
  - Provider manual (varies by provider type)
  - Program or provider specific information, program coverage, prior authorization, reimbursement and billing procedures
- Section III
  - Billing information: General information, remittance advice and status report, adjustment request, additional or other payment sources, pseudo claims and reference books

Provider Manuals

- Section IV
  - Glossary: Arkansas Medicaid acronyms and terms
- Section V
  - Claim forms, Arkansas Medicaid forms, contacts and links

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

Procedure Code Linking Tables

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1st
- Access to a computer, smartphone, or tablet that is new enough to…

2nd
- Access to the internet…
- With a current web browser…

3rd
- And have Microsoft Excel and Word installed...

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Procedure Code Tables List

Procedure Code Linking Tables	
Adult Behavioral Health Services for Community Independence (ABHSCI)	Hyperalimentation
Adult Developmental Day Treatment (ADDT)	Independent Laboratory
Ambulatory Surgical Center (ASC)	Independent Radiology
ARKids First-B	Nurse Practitioner (NP)
Autism Waiver	Occupational Therapy, Physical Therapy, and Speech- Language Pathology Services
Autism EPSDT	Oral Surgeon (Dental Procedure Codes or Physician Procedure Codes)
Certified Nurse Midwife (CNM)	Outpatient Behavioral Health Services (OBHS)
Certified Registered Nurse Anesthetist	Physician
Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Podiatrist
Children's Services Targeted Case Management	Portable X-ray Services
Chiropractic	Primary Care Physician
Critical Access Hospital	Private Duty Nursing (PDN)
Dental	Prosthetics (Includes Durable Medical Equipment & Orthotics)
Developmental Therapy Services	Radiation Therapy Center
Early Intervention Day Treatment	Rehabilitative Hospital
Early Intervention Day Treatment Academic Medical Center	Rural Health Center (RHC)
End-Stage Renal Disease	School-Based Mental Health (SBMH)
Family Planning Clinic	Transportation
Federally Qualified Health Center (FQHC)	Ventilator Equipment
Hearing/Audiology	Visual Care
Home Health	
Hospital	

Fee Schedules

The fee schedules do not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., client and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, and co-payments/coinsurance where applicable). **Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.**

Although every effort is made to ensure the accuracy of this information, discrepancies may occur. These fee schedules may be changed or updated at any time to correct such discrepancies. The reimbursement rates reflected in these fee schedules are in effect as of the run date for the report. The reimbursement rate applied to a claim depends on the claim's date of service because Arkansas Medicaid's reimbursement rates are date-of-service effective. These fee schedules reflect only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of $0.00 is manually priced.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For disclaimers specific to the provider type, please refer to the disclaimer text in each fee schedule file. For a full explanation of the procedure codes and modifiers listed here, refer to your Arkansas Medicaid provider manual.

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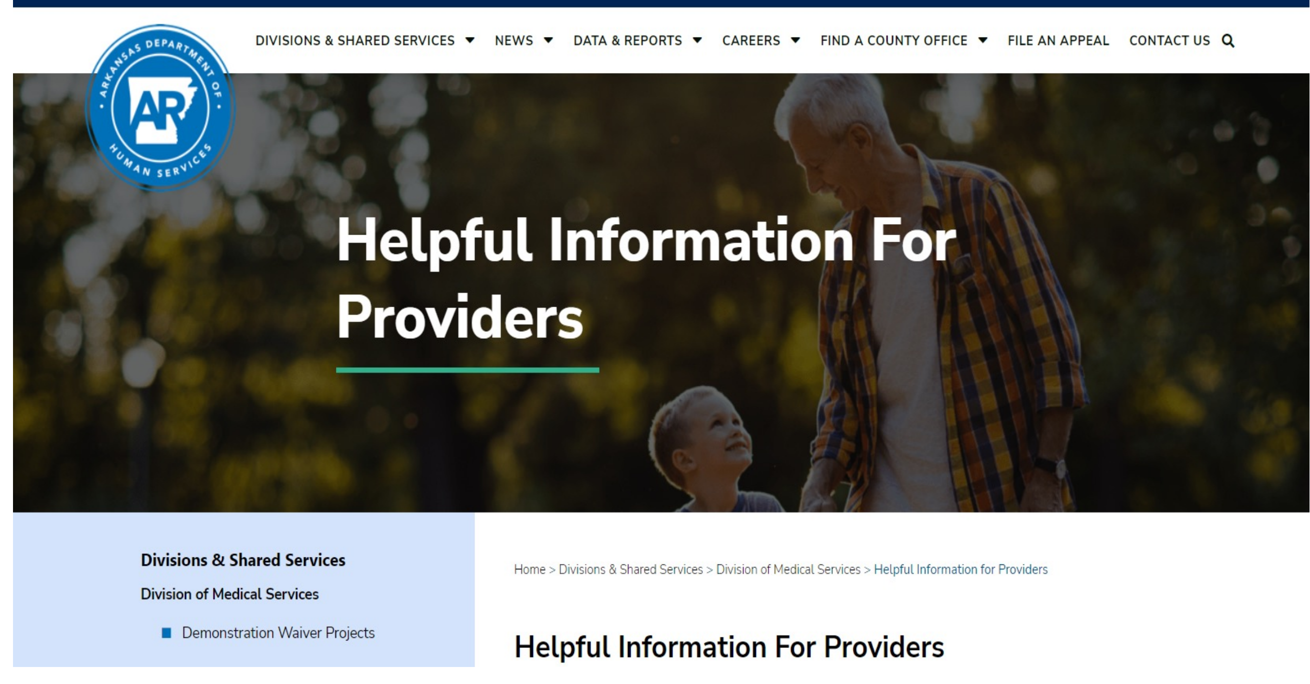
Helpful Information for Providers

[Helpful Information for Providers]

- Access the Provider Portal (check eligibility, submit a PA request, or submit claims)
- Billing Manuals
- Fee Schedules
- PCMH / PCCM
- Provider Training Information
- Sign-up for MMIS email updates
- State Plan (Medicaid and CHIP)



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Tips for Provider Manuals and Fee Schedules

Read ***your*** Provider Manual

Section II is specific to your specialty

Procedure code tables are accessible in the manual with hyperlinks

Sections I, III, IV and V are the same in all manuals

Use Control F to search

Manual updates are highlighted in yellow

Always check manuals, official notices, remittance advice banners and fee schedules for up-to-date information

Official Notices outweigh the manual

Always follow Policy

TIME FOR A BREAK

Prior Authorization

Prior Authorization Requirements

- Choose the Right Process Type
- Modifiers on Claims and Prior Authorizations
- Attaching Documentation
- Reconsiderations
- PA Letters

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AFMC Prior Authorization Process Types on the Portal

- Anesthesia
- Assistant Surgeon
- Hyperalimentation
- Hyperbaric Oxygen Therapy
- Inpatient Services
  - MUMPs/Continued inpatient stay reviews and Acute crisis unit reviews)
- Lab and Radiology
- Lab Molecular Pathology
- Orthotics and Prosthetics
- Physician Administered Drugs
- Professional Services
  - Surgical procedures and Extension of Benefit requests for office visits, adult therapy visits
- Ventilators and Equipment
- Viscosupplementation

Note: These process types are processed by AFMC

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State Medical Prior Authorization Process Types on the Portal

- Augmentative Communication Device Evaluation
- Developmental Rehab Services
- Disposable Medical Supplies
- Eye Prosthetics
- First Connections
- Hearing Services
- Home Health Visit Extensions
- Private Duty Nursing
- Special Procedure Codes
- Targeted Case Management
- Title V
- Vision

Note: These process types are processed by the State

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State Dental Prior Authorization Process Types on the Portal

- Adult dental
- Child dental
- Orthodontics

Note: These process types are processed by the State

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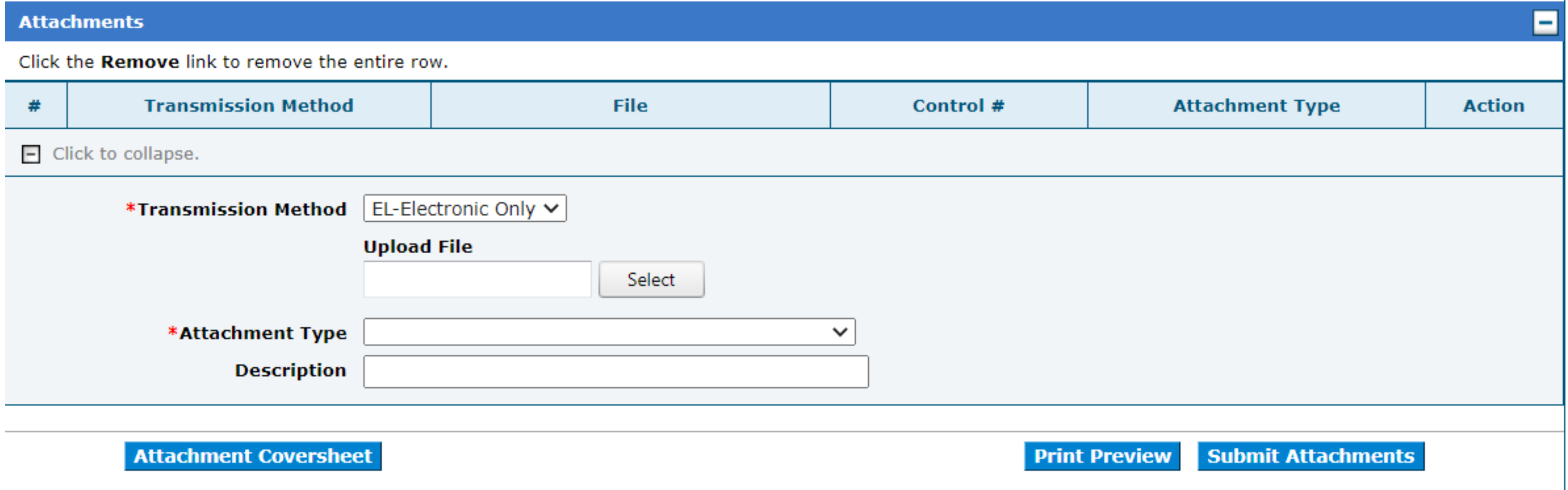
Modifiers on Claims and Prior Authorizations

When requesting a prior authorization, include all modifiers on the prior authorization that will be used and/or needed on the claim.

This is to include payment impacting, anatomical and informational modifiers.

If the system does not find an exact match on the procedure code and modifier combination, the prior authorization will be determined to not be found and the claim will either cut back or deny.

How to Attach Documents to a PA Request



Prior Authorization

Reconsiderations

According to (URAC) policy

- A reconsideration can be made on any PA where a PA line item has been denied or approved with modifications
- No need to request a new PA
- You get one chance to request a reconsideration
- A request for reconsideration must be submitted within 35 calendar days from the date of the Prior Authorization denial letter

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Example of a Reconsideration on the Portal

Service Provider / Service Details Information

If both authorized units and dollars are displayed, the dollar amount is a per unit rate.

All required attachments must be attached before selecting items for reconsideration and all line items to be selected for reconsideration must be selected at the same time.

Service Details

	From Date	To Date	Units	Amount	Code	Status	Reconsider	Modifiers	Reason
⊞	04/01/2019	04/01/2019	1	_	CPT/HCPCS 99213-OFFICE O/P EST LOW 20-29 MIN	DENIED	☐	_	_

Expedited Reconsiderations

According to (URAC) Policy

If you have an expedited reconsideration, please choose the appropriate option on the reconsideration panel of the Healthcare Portal. Please keep in mind, you will be asked to attest to URAC standards. URAC statement must be acknowledged before expedited PAs can be reviewed.

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Example of an Expedited Reconsideration on the Portal

Service Provider / Service Details Information

If both authorized units and dollars are displayed, the dollar amount is a per unit rate.

All required attachments must be attached before selecting items for reconsideration and all line items to be selected for reconsideration must be selected at the same time.

Service Details

	From Date	To Date	Units	Amount	Code	Status	Reconsider	Modifiers	Reason
⊞	04/01/2019	04/01/2019	1	_	CPT/HCPCS 99213-OFFICE O/P EST LOW 20-29 MIN	DENIED	☑	_	_

Expedite Reconsideration ☑

To expedite this request you must attest that expedited request meets the following guidelines:
I am a physician/physician representative with knowledge of the patient's medical condition; it is my opinion that failure to expedite this appeal will delay the patient's receipt of urgent care, and that such delay could:
a) seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function; or
b) would subject the consumer to severe pain that cannot be adequately managed without the urgent care or treatment that is the subject of this matter.

I Attest ☐

Example of a Prior Authorization Letter

Prior Authorization Letters

Sequence	Letter Creation Date	Letter Category	Link to Prior Authorization Letters
1	04/07/2021		LOD.PAU-A002-D.80332.1259820210123013453.PDF

Tips for Prior Authorization Requests

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

Always choose the correct Process Type

Refer to Section II of ***your*** provider manual and Official Notices for Prior Authorization policy and instructions

Access the Procedure Code Tables on the DHS website under Helpful Information for Providers

Quick Track Training Material is available on the DHS website under Provider Training Information

Contact information for ***ALL*** Process Types is located on the Care Management tab landing page of the Healthcare Portal

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Healthcare Provider Portal

ARMedicaid

Contact Us | Logout

Home | Eligibility | Claims | Care Management | Provider Functions | Files Exchange | Resources

Home

Thursday 01/26/2023 08:44 AM CST

Provider Name PCP PROVIDER **Role IDs** Provider - In Network - 1111111112 (NP

User Details

Welcome PCP Provider

- My Profile
- Manage Accounts

Provider

Name PCP PROVIDER
Provider ID 1111111112 (NPI)
Revalidation Date 03/01/2022

- Characteristics

Provider Services

- Search Payment History
- MAPIR

Welcome Health Care Professional!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Help us provide better service to you! Click here to give us your feedback

Authenticare Demo – For Personal Care Providers required to participate in Electronic Visit Verification

Contact Us

Secure Correspondence

All Claim Inquiries should be submitted to the following Address:

Claims
Gainwell Technologies
PO BOX 8034
LITTLE ROCK, AR 72203

Healthcare Portal Features

- Online provider enrollment application
- Eligibility verification
- Submit all claim types (professional, institutional, dental, crossover and third-party)
- Ability to edit (adjust), void and copy claims
- View status of claims
- Attachments for claims and prior authorizations
- Prior authorization request and status check
- Real-time claims processing
- Remittance advice held up to seven years
- Secure correspondence

Tips for Healthcare Portal

- At least 5MB of upload and download speed
- Everyone has their own username and password
- Make sure staff that is no longer employed is inactive on your profile
- Claims can be submitted 24/7
- Claims submitted electronically must be entered by 6 p.m. on Friday
- Check Eligibility the day you provide service
- Submit claims electronically for faster payment
- Check Portal for claim status
- Resubmit denied claims using the portal

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HOT TOPIC!

What is PERM?

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The PERM program is designed to measure improper payments in the Medicaid and CHIP programs. During each PERM Cycle, CMS hosts multiple provider education sessions which are presented on webinar/conference call platforms.

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Purpose of PERM

The purpose is to provide opportunities for the providers of the Medicaid and Children's Health Insurance Program (CHIP) communities to enhance their understanding of specific Provider responsibilities during the PERM.

How does it work?

CMS selects a random selection of claims that require additional information from AR Medicaid providers. If you receive a request for medical records, please submit the requested information by the deadline provided in the letter. Failure to comply with the request can result in recoupment and/or penalties.

Please note: The most recent letters are being distributed as early as March 2024.

Things to Remember

Always check eligibility before providing services.

Read Section II of *your* manual.

Contact the right vendor or entity if you have questions.

Use training resources.

Non-emergency transportation opportunities for Medicaid clients

New provider workshops are conducted quarterly.

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Medicaid Contacts

- Division of Medical Services (DMS)
  humanservices.arkansas.gov/divisions-shared-services/medical-services/
- County offices (DCO)
  humanservices.arkansas.gov/find-a-county-office/
- AFMC
  afmc.org
  - MMIS outreach specialists - 501-906-7566, afmc.org/mmis
  - ConnectCare - 1-800-275-1131, seeyourdoc.org
  - Provider relations outreach specialists - afmc.org/providerrelations
  - AFMC Clinical Services - 479-649-8501, clinicalservices@afmc.org
- Acentra Health: Prior authorization and extension of benefits - Ar.pr@eqhs.com or 1-888-660-3831
- Office of Medicaid Inspector General (OMIG) 1-855-527-6644
- Magellan Medicaid Administration pharmacy help desk 1-800-424-7895, Option 2 for prescribers
- Gainwell Technologies 1-800-457-4454
- PASSE-DHS PASSE provider call center 1-888-889-6451
- MCNA Dental 1-800-494-MCNA
- Delta Dental Smiles Customer Service 1-866-864-2499

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Medicaid Tools and Resources

DHS/DMS website: Helpful Information for Providers

- Provider manuals
- Procedure code tables
- Fee schedule
- Frequently asked questions (FAQs)
- Vendor specifications
- Job aids
- Quick tracking training videos and guides
- *MyARMedicaid Application*

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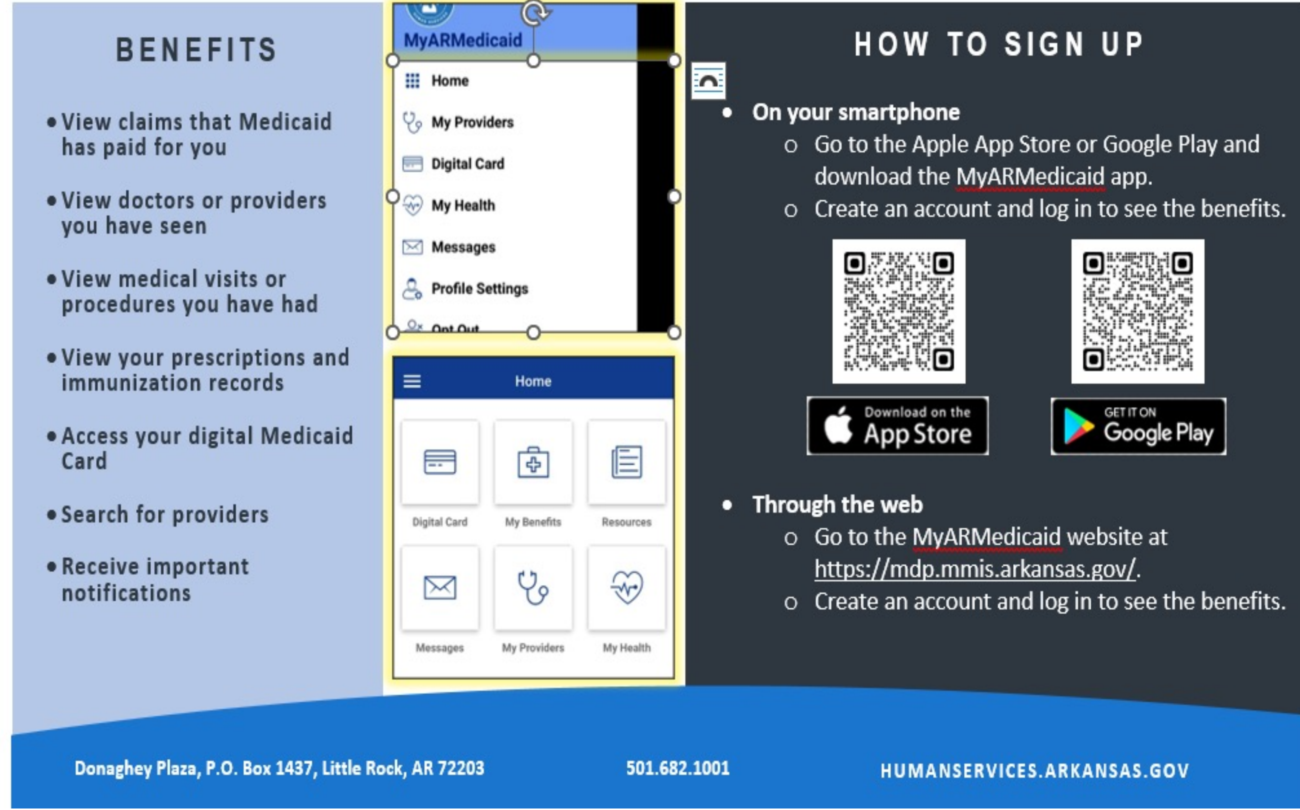
Download the MyARMedicaid App



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E-Blast Sign-Up Link

Sign-up for MMIS email updates

Name *

First

Last

Email *

Submit

[AFMC MMIS E-Blast Sign-Up Link]

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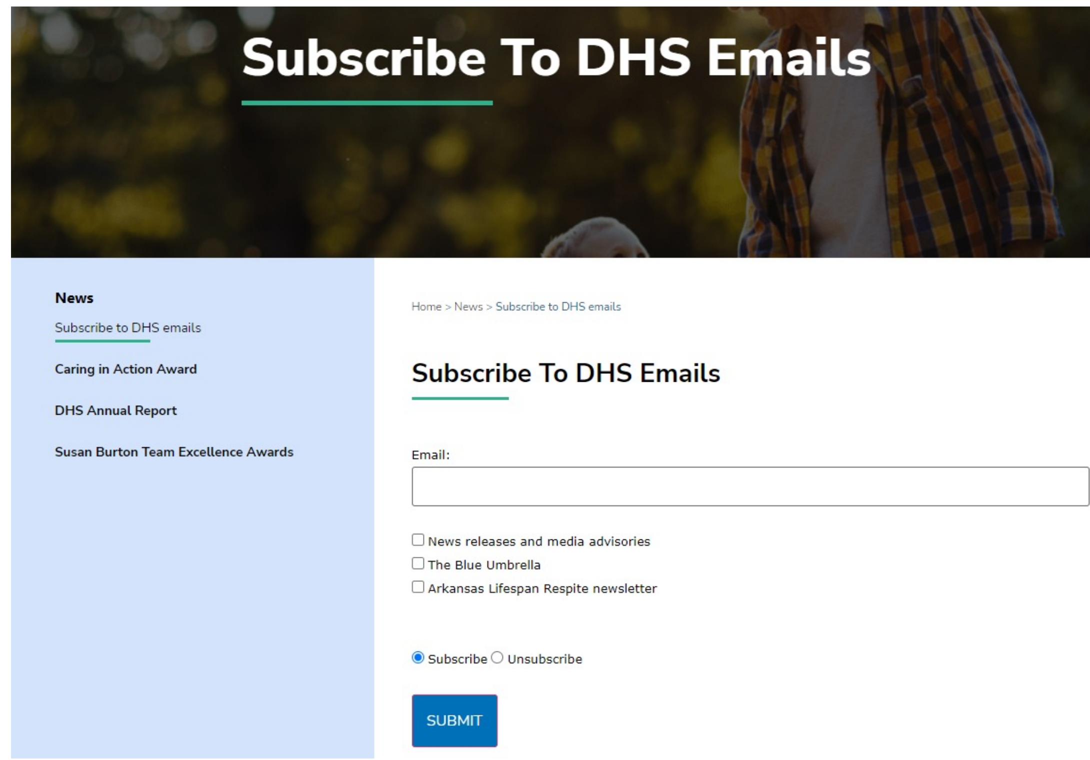
DHS Email Notifications

[DHS Email Notifications]



Evaluations

Your feedback is important to us!

Please take time to complete the evaluation that will be emailed to you.

Attendance certificate will be available to print.

Thank you for attending today!

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Questions?