ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PHYSICIAN MEDICAID UPDATE
Q1 SFY2024
(July–September 2023)

What's New for Arkansas Medicaid Providers

- New Official Notices
- New Provider Manual Updates
- New RA Messages

Primary Care Providers - Managing Your AR Medicaid Beneficiary Caseload

As an AR Medicaid Primary Care Provider (PCP), you have contracted with the Division of Medical Services (DMS) to be responsible for managing the health care of a limited number of Medicaid beneficiaries. As the provider, you get to determine the number of Medicaid beneficiaries you want assigned to you, the counties from which you want to accept beneficiary assignment and the beneficiary age range for which you choose to provide services.

If you are an AR Medicaid PCP, it is important to understand how beneficiaries can be assigned to you and how to manage your Medicaid beneficiary caseload. If you keep an open caseload, AR Medicaid beneficiaries can choose you as a PCP and initiate assignment through their local Division of County Office, via web request through www.seeyourdoc.org, and/or a phone call to the toll free ConnectCare line – 800-275-1131. Hospitals can assign an AR Medicaid beneficiary to you via the voice response system (VRS) if they present to the Emergency Room without an assigned PCP. Hospital staff must forward a copy of the selection form (DMS-2609) to the assigned PCP after assignment is complete. The PCP can also assign beneficiaries through the online portal, fax, and/or the VRS. The assignment of beneficiaries to a PCP is not open to all provider types.

A PCP can manage their Medicaid beneficiary caseload through the MMIS portal by lowering or increasing the maximum number they wish to accept. The job aid Provider Portal: Updating PCP Caseload can be found here - https://humanservices.arkansas.gov/wp-content/uploads/MMIS_JobAid_UpdatingPCPCaseload.pdf. Age limits can also be managed through the MMIS portal. Please review section 171.210 for instructions if your provider wishes to exceed the 2500 beneficiary maximum caseload limit. In addition to the verbiage provided in section 171.210 E4 – a copy of the letter requesting a caseload increase should be provided to your AFMC Outreach Specialist.

Along with reimbursing PCPs on a fee for service basis for provided services, AR Medicaid pays a monthly case management fee for each enrollee on their caseload. It is important for providers to review their assigned beneficiaries to ensure they are being seen by their PCP. A report of your assigned beneficiaries is available on the MMIS portal. You can utilize the Files Exchange Job aid for Health Care Innovation (HHI) for direction on how to access the latest quarterly managed care report. The job aid can be found here - https://humanservices.arkansas.gov/wp-content/uploads/MMIS_JobAid_FilesExchangeHCI.pdf.

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Section 173.620 in all Provider Manuals provides direction for PCP transfers by PCP request. Please review the manual language for unacceptable arrangements between the beneficiary and PCP that allows for dismissal by the PCP. In addition to the verbiage provided in section 173.620 B2 – the letter should include the beneficiary's name, date of birth, Medicaid ID and the reason for dismissal. It should also be submitted to your AFMC Outreach Specialist via fax @ 501-375-0705 or secure email. When a dismissal letter is received the beneficiary will be removed from the PCPs caseload once the thirty-day period has ended. The beneficiary is locked out from choosing the PCP that dismissed the beneficiary.

If you have further questions on how to manage your caseload, please reach out to your AFMC Outreach Specialist.

105.130 ConnectCare: Primary Care Case Management (PCCM) 10-1-12

ConnectCare is the Arkansas Medicaid Primary Care Case Management (PCCM) system. In ConnectCare, a Medicaid beneficiary selects and enrolls with a primary care physician (PCP) that has contracted with DMS to be responsible for managing the health care of a limited number (specified by the PCP) of Medicaid enrollees.

A PCP contracts with DMS to provide primary care, health education and case management for his or her enrollees. DMS pays the PCP a monthly per-enrollee case management fee in addition to the regular Medicaid fee-for-service reimbursement.

The PCP is responsible for referring enrollees to specialists and other providers; therefore, he or she is responsible for deciding whether a particular referral is medically necessary. A PCP may make such decisions in consultation with physicians or other professionals as needed and in accordance with his or her medical training and experience; however, a PCP is not required to make any referral simply because it is requested.

A PCP coordinates his or her enrollees' medical and rehabilitative services with the providers of those services. Medical and rehabilitative professionals to whom a PCP refers a patient are required to report to or consult with the PCP so that the PCP can coordinate care and monitor an enrollee's status, progress and outcomes.

Most Medicaid beneficiaries, and children participating in ARKids First-B, must enroll with a PCP to receive covered services. Some individuals are not required to enroll with a PCP. Few services are covered without PCP referral. See Sections 170.000 through 173.000 for details regarding ConnectCare.

171.210 ConnectCare Caseload Maximum and PCP Caseload Limits 10-8-10

A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500.
   1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
   2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create a hardship for them, their patients and/or the community they serve.

B. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum.

C. At any time, a PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by submitting a written request to the Provider Enrollment Unit, or on-line through the Medicaid website (https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/), Provider Enrollment Information, and Access to the Provider Information Portal.

D. To request an increase in a PCP caseload above the default maximum, the PCP must submit a written request to the Provider Enrollment Unit. View or print Provider Enrollment Unit contact information.

E. Prior to making the request for an increase of a caseload that is already at the default maximum, PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload. To do so, PCPs may use the Arkansas Medicaid Information Interchange (AMII) web portal. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:

1. Contact the patient in writing at least 30 days in advance of the effective date of the termination to give the patient the option of making a visit to the PCP to remain an active patient. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of 30 calendar days.
2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the 30 calendar day notification process of inactive patients.
3. The notice must state that the enrollee has 30 calendar days in which to enroll with a different PCP.
4. The PCP must forward a copy of the notice to the enrollee and to the local DHS office in the enrollee's county of residence.

173.400 PCP Selection and Enrollment at Participating Hospitals 7-1-05

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

A. Enrollment is by means of a Primary Care Physician Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).

1. Hospital personnel enter the PCP selection via the VRS.
2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.

B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.

C. The enrollee may request and receive a copy of the completed selection form.

D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.620 PCP Transfers by PCP Request 9-15-09

A PCP may request that an individual transfer his or her PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

A. Examples of unacceptable arrangements include, but are not limited to, the following.

1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
2. The enrollee is abusive to the PCP.
3. The enrollee does not comply with the PCP's medical instruction.

B. At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.
   1. The notice must state that the enrollee has 30 days in which to enroll with a different PCP.
   2. The PCP must forward a copy to the enrollee and to the local DHS office in the enrollee's county of residence.

C. The PCP continues as the enrollee's primary care physician during the 30 days or until the individual transfers to another PCP, whichever comes first. ■

Keeping You Informed

AR Medicaid Providers - Keep Your Address and Email Information Up to Date

AR Medicaid policy states each provider must notify the AR Medicaid Provider Enrollment Unit in writing immediately regarding any changes to their application or contract status. A requirement that often gets overlooked is the updating of a provider's physical address and email address. Section 141.000 – (H) states an active email address is required. The DMS-673 form can be found in section V of all AR Medicaid manuals and is the appropriate form to use to update this information. The completed form can be uploaded in the provider's MMIS portal or mailed to:

Medicaid Provider Enrollment Unit – Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105

Providers are also required to revalidate their enrollment with AR Medicaid every 5 years regardless of provider type. The Arkansas Medicaid Provider Enrollment Unit will send a letter 90 days prior to the revalidation deadline to the "mail to" address on file. If the provider fails to send in the revalidation application by the deadline, Arkansas Medicaid will terminate their contract after 60 days of the revalidation expiration date and interrupt the processing of their AR Medicaid claims.

Providers can go to https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx to log into the portal and check their revalidation deadlines or to submit a revalidation application online using the instructions below.

Instructions for submitting application:

- Under "Would you like to enroll as a Provider or a Trading Partner?" click the Provider link.
- Click the Enrollment Application link.
- Enter your information and when you reach the question, "Are you currently enrolled as a Provider?" click yes, and then enter the provider ID.

Here are some tips for helping your provider application or re-enrollment process go more smoothly.

- Apply online. Use the assigned tracking number to check your application's status. You can also renew and revalidate your enrollment online using Resume Enrollment.

- You must submit credentials annually. A good rule of thumb is to Resume Enrollment on the Health Care Provider Portal when you mail your license/certification renewal fees to your state. Please make certain you attach the current license. Always check the expiration date before attaching.
- When submitting credentials for re-enrollment, always add your provider number. This will help us process your renewal more quickly if there are several providers under the same tax ID number.
- When enrolling for Electronic Fund Transfer (EFT) Authorization for Automatic Deposit, you must attach a voided check or a signed letter from the bank. Deposit slips are not accepted to set up EFTs.
- If you have been inactive with Arkansas Medicaid for 6 months, you must submit a new application.
- W-9 forms and contracts for individual providers must be submitted in their name, with their Social Security number, and their original signature. If the W-9 or contract is for a group or facility, it must include the tax ID number and an original signature.

Additional Provider Enrollment information can be found on Arkansas Medicaid's website - https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/.

141.000 Provider Enrollment 11-1-17

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers may enroll on the Arkansas Medicaid website at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/. Potential providers that are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. View or print the Provider Enrollment contact information.

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification

renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. View or print the provider enrollment and contract package (Application Packet).

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

A. W-9 Tax form (DMS-652)

B. Medicaid Provider Contract (DMS-652)

C. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)

D. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)

E. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

F. Authorization for Electronic Funds Transfer (Automatic Deposit)

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.

B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application

C. Authorization for Electronic Funds Transfer (Automatic Deposit)

D. Change in practice or specialty

E. Retirement or death of provider

F. Name Change Form

G. Change of Ownership Form (DMS-0688) (View or print form DMS-0688 – Provider Change of Ownership Information Form.)

H. Address/Email Change Form (DMS-673) (View or print form DMS-673 – Address/Email Change Form.) NOTE: An active email address is required.

I. Change in Ownership Control (5% or more) or Conviction of Crime (View or print form DMS-675 – Ownership and Conviction Disclosure.)

J. Disclosure of Significant Business Transactions (View or print form DMS-689 – Disclosure of Significant Business Transactions.)

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) unless the provider is an atypical provider not required to have an NPI.

141.100 Revalidation of Enrollment 7-1-13

Federal regulation 42 CFR 455.414 requires Arkansas Medicaid to revalidate the enrollment of all providers regardless of provider type, at least every 5 years. Revalidation of an enrollment includes:

A. Submission of a new application,

B. Payment of application fee, if applicable (See Section 141.102 for Application Fees requirements.), and

C. Satisfactory completion of screening activities.

The revalidation notice will be sent to the provider 90 days before their revalidation deadline using the "Mail To" address on file. **It is important that providers keep their address information up to date to ensure that they receive this notice**. Failure to submit the required documentation prior to the deadline will interrupt the ability to have claims paid.

Providers enrolling on or after July 1, 2013 will have a future revalidation date set at the time of their enrollment. All providers that were enrolled before July 1, 2013 will be required to revalidate their enrollments upon receipt of notice from Medicaid Provider Enrollment. This initial revalidation will determine the revalidation cycle for providers. ■

Keeping You Informed

Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to beneficiaries eligible for full range medical benefits from birth through age 20. Even if the beneficiary eligible for full range medical benefits is a parent, he or she is eligible for Child Health Services (EPSDT) through age 20. All beneficiaries in a full range Medicaid benefit plan, including those in the ARKids A benefit plan are eligible to receive EPSDT services.

ARKids A beneficiaries receive all Medicaid benefits. The policies which speak to the services an ARKids A beneficiary and other beneficiaries in a full range benefit plan may receive are outlined in each service type provider manual. All Medicaid provider manuals can be found on this webpage - https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/

ARKids First-B beneficiaries receive preventive health care screens and treatment options within covered benefits through age 18. Covered services provided to ARKids First-B beneficiaries are within the same scope of services provided to ARKids A beneficiaries. However, some ARKids First-B services are subject to different levels of benefits and cost sharing amounts are applied. The ARKids First-B service restrictions and required co-payment/co-insurance or cost-sharing amounts for covered services are outlined in the ARKids First-B manual. ■

Keeping You Informed

Primary Care Providers – Region Selection

Providers enrolled in the Primary Care Case Management Program (PCCM) are allowed to choose 20 regions from which to assign new Medicaid enrollees. Regions can also be referred to as counties.

Medicaid beneficiaries in aid categories that require a Primary Care Provider (PCP) assignment must select a PCP located near his or her residence. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence, or a county that adjoins a county adjacent to the county of residence. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence if that PCP is enrolled with Arkansas Medicaid.

A Primary Care Provider must complete a DMS-2608, PCP Participation Agreement form to participate in the PCCM Program. PCPs will use this form to select all the counties in Arkansas in which he or she will provide primary care physician services. https://humanservices.arkansas.gov/wp-content/uploads/DMS-2608.pdf

If you are updating the DMS-2608 to include additional counties, be sure to select all counties you wish to serve, not just the new counties you want added.

It is very important to choose the county of the primary practice location and all the surrounding adjoining and adjacent counties. PCPs who practice in multiple locations will need to include the county of all practice locations that they serve as well as the surrounding adjoining and adjacent counties.

If a Medicaid beneficiary selects a PCP who does not accept new enrollees from the beneficiary's county of residence, that assignment will not be completed, and they will receive an "out of region" denial.

If you have any questions regarding region selections or how to complete the DMS-2608, you can reach out to Gainwell Technologies Provider Enrollment. https://humanservices.arkansas.gov/wp-content/uploads/ProviderEnrol.doc ■

Keeping You Informed

Primary Care Provider Referrals

173.000 PCCM Selection, Enrollment and Transfer 7-1-05

A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP in order to obtain a PCP referral for medical services.
   1. All newly eligible individuals are given opportunities to enroll.
   2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders from ConnectCare of the advantages of PCP enrollment.

B. An individual must select a PCP that is located near his or her residence.
   1. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence or a county that adjoins a county adjacent to the county of residence.
   2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

Most Medicaid beneficiaries must enroll with a Primary Care Provider (PCP) to receive covered services. Medicaid beneficiaries may obtain services only from their PCP unless their PCP refers them to another provider, or they receive a service that doesn't require a PCP referral. Section 172.100 of all Medicaid provider manuals provides a complete list of services that do not require a PCP referral.

PCP referral requirements can be found in section 171.400 of all Medicaid provider manuals. The PCP is responsible for referring beneficiaries to other providers and deciding whether a referral is medically necessary. A beneficiary's PCP determines whether it is necessary to see the beneficiary before making or renewing a referral. A PCP is not required to make a referral because it is requested, and PCPs aren't required to make retroactive referrals. Medicaid and ARKids First-B beneficiaries are responsible for any charges incurred for services obtained without PCP referrals except for those services listed in Section 172.100 of all Medicaid provider manuals.

PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP, or in six months, whichever occurs first. This requirement varies in some programs. Applicable regulations are outlined in the appropriate Arkansas Medicaid Provider Manuals. AR Medicaid provides an optional form (DMS-2610) to facilitate referrals. The form can be found in section V of all Medicaid provider manuals. Please ensure all components are covered if you utilize a referral form generated by your Electronic Health Record. PCP referrals may be provided verbally, by note or letter, and submitted via fax. Regardless of how the referral is provided, AR Medicaid requires documentation of the referral in the beneficiary's medical record. More information is provided in section 171.410 of all Medicaid provider manuals.

171.400 PCP Referrals 1-1-18

A. Referrals may be only for medically necessary services, supplies or equipment.

B. Enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.

I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

171.410 PCCM Referrals and Documentation 7-1-05

A. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. View or print form DMS-2610.
   1. Additionally, PCP referrals may be oral, by note or by letter.
   2. Referrals may be faxed.

B. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.
   1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.
   2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

172.100 Services not Requiring a PCP Referral 9-1-20

The services listed in this section do not require a PCP referral:

A. Adult Developmental Day Treatment (ADDT) core services;

B. ARChoices waiver services;

C. Anesthesia services, excluding outpatient pain management;

D. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists. The physician and facility assessment services do not require a PCP referral (if the Medicaid beneficiary is enrolled with a PCP);

E. Chiropractic services;

F. Dental services;

G. Developmental Disabilities Services Community and Employment Support;

H. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS;

I. Emergency services in an acute care hospital emergency department, including emergency physician services;

J. Family Planning services;

K. Gynecological care;

L. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

M. Mental health services, as follows:
   1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
   2. Medication Assisted Treatment for Opioid Use Disorder when rendered by an X-DEA waivered practitioner
   3. Rehabilitative Services for Youth and Children (RSYC) Program

N. Obstetric (antepartum, delivery, and postpartum) services
   1. Only obstetric-gynecologic services are exempt from the PCP referral requirement
   2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
   3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider

O. Nursing facility services and intermediate care facility for individuals with intellectual disabilities (ICF/IID) services;

P. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye;

Q. Optometry services;

R. Pharmacy services;

S. Physician services for inpatients in an acute care hospital, including direct patient care (initial and subsequent evaluation and management services, surgery, etc.), and indirect care (pathology, interpretation of X-rays, etc.);

T. Hospital non-emergency or outpatient clinic services on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment;

U. Physician visits (except consultations, which do require PCP referral) in the outpatient departments of acute care hospitals but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

V. Professional components of diagnostic laboratory, radiology, and machine tests in the outpatient departments of acute care hospitals, but only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations;

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services;

X. Transportation (emergency and non-emergency) to Medicaid-covered services; and

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity or would create unnecessary hardship.

As indicated in section 171.400 B - Client free choice must be ensured by naming two or more providers of the same type of specialty when completing the PCP referral DMS-2610 form. This means that individual provider information must be populated in the section of the referral form below, not a group name. ■

Medicaid Providers Receiving Referral:

Per Medicaid policy (Section 171.400, B.) two or more providers of the same type or specialty must be listed in the receiving referral section to ensure member free choice.

1. _____ _____ _____
Physician first and last name | Medicaid Provider ID# | Date of referral

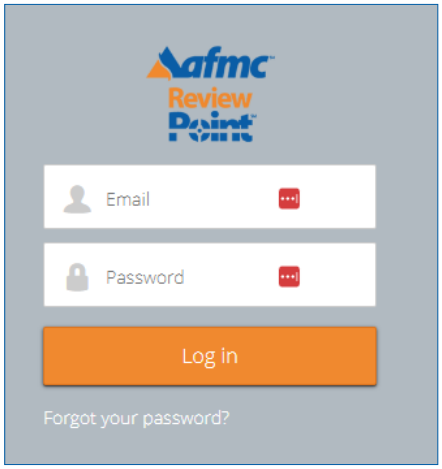
2. _____ _____ _____
Physician first and last name | Medicaid Provider ID# | Date of referral

Keeping You Informed

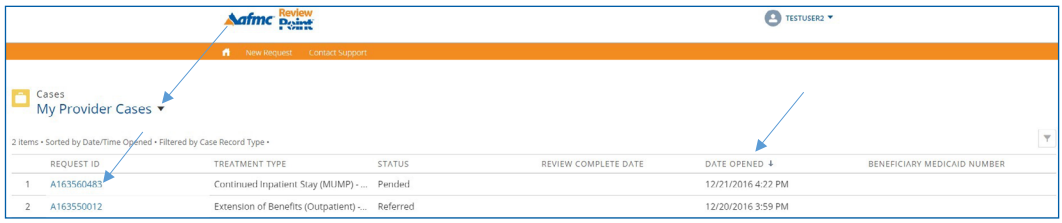
ReviewPoint Web Portal

Each month, AFMC sends out random selections of claims that were billed for the previous month for Arkansas Medicaid, including claims for emergency room visits, inpatient acute care hospital stays, and hospital-acquired conditions. ReviewPoint is a web portal where you can submit and check the status of your reviews. Through this portal, you can also submit a reconsideration request if your initial review is denied. Follow the steps below for a step-by-step look at reviewing old cases, submitting new cases, and submitting a reconsideration request.

- Once registered in ReviewPoint, go to https://reviewpoint.afmc.org/. Log in using your user ID and password on this login screen.

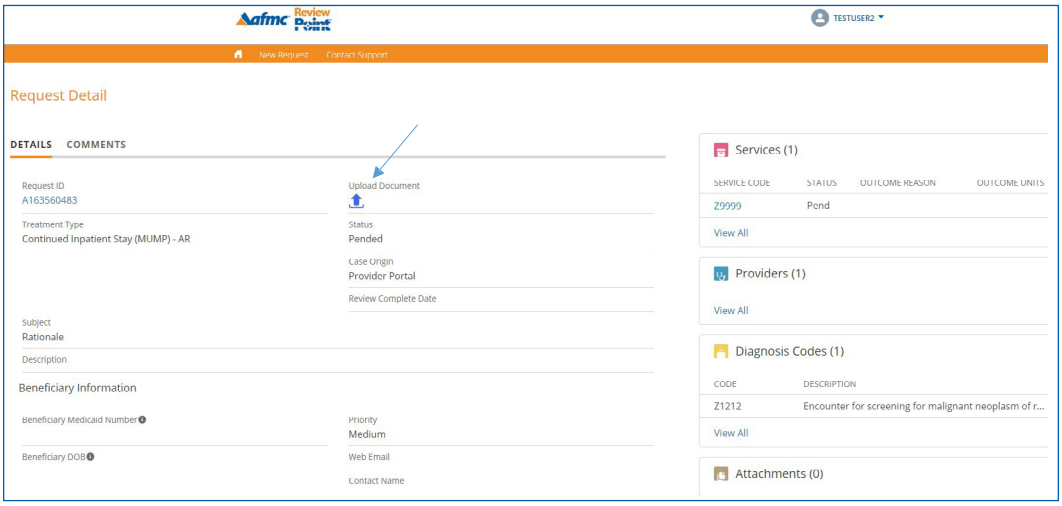


- Your home page will look like this:



- Click on "My Provider Cases" to see a drop-down list of your view options.
- Once you begin submitting cases, you will see all cases submitted within the last 90-days on your home screen. You will see what type of review was submitted, the status of the review, and when it was submitted – "Date Opened."

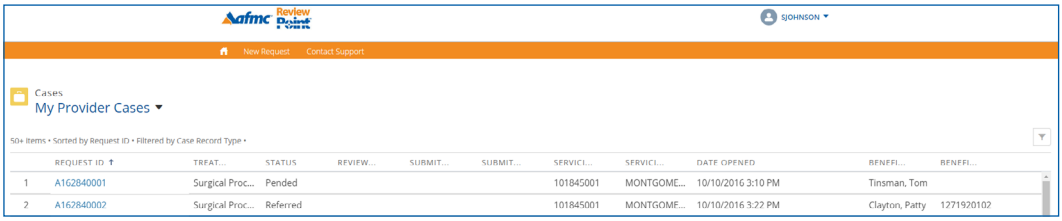
- Click on the "Request ID #" in blue on your home page. This will take you to the "Details" page where you can upload the medical record by clicking the blue arrow under "Upload Document."



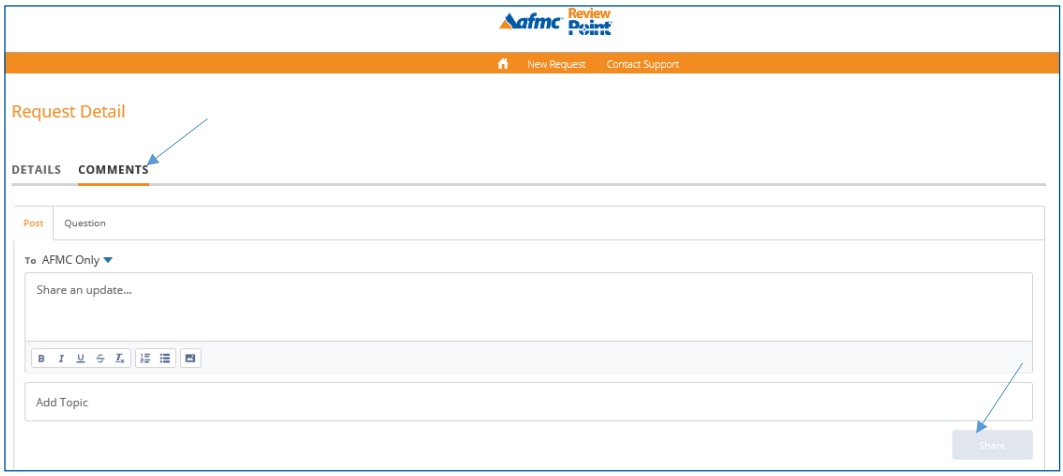
- Once you click the blue arrow to upload a document, you will see this screen:

- You will need to type in a name for your file first such as the request ID number: A163560483
- Then click "Choose File" to browse your documents and choose the correct file.
- Once you have your file selected, you must select Yes or No in answer to the question: "Is this for a reconsideration?"
- Click the "Upload" button.
- Return to the home screen to continue uploading records by clicking on the house icon in the gold bar:

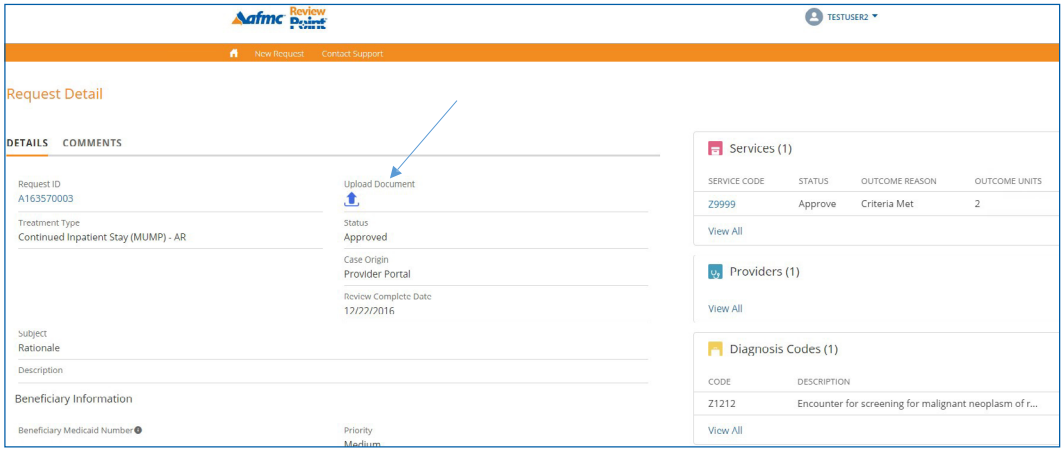
- To locate a case in your provider cases, you can sort by "Date Opened" or click on "Request ID" column to sort in ascending or descending order. You can also sort by clicking on the "Status" column. Then click on the Request ID to open the case and view the details of the case.



- If you see in your Provider Cases listing that a case is denied, click on the "Request ID" to get to the case details. Then click "Comments" next to the word "Details" to submit a reconsideration request to AFMC. Reconsideration requests must include new information not previously considered by our clinical services team.



- Type in your comments, name, and phone number to request a reconsideration in the "Share an update…" field and click "Share." You will not be able to view your comments in the portal. They are submitted to the appropriate review staff person at AFMC. Your name and phone number are needed in case the review staff person has questions. Click on the "Details" tab to be able to upload additional information after submitting your comments.
- To attach additional documentation or information, click on the blue arrow under "Upload Document" to upload your information.
- See instructions above for uploading a document. Be sure and click "Yes" in answer to the question "Is this for a reconsideration?"



For any questions regarding specific reviews, please email ClinicalServices@afmc.org. If you need help with the ReviewPoint portal, please email ReviewPoint@afmc.org. ■

What's New for Arkansas Medicaid Providers

Official notices posted from April 1, 2023 – June 30, 2023. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
COVID-19 changes with the Ending of the Public Health Emergency (PHE) – and – CMS COVID Vaccine and Admin Codes Changes as of 4/18/2023	6/16/2023	COVID-19
2023 Quarter 2 Healthcare Common Procedure Coding System Level II (HCPCS) Code, Current Procedural Terminology (CPT)	5/26/2023	Procedure Codes
Prior Authorization (PA) Removed from Prosthetic Codes for Under 21	5/19/2023	Procedure Codes
Psychological Testing and Evaluation Services	5/15/2023	Procedure Codes
E2510 requires PA	5/4/2023	Procedure Codes
Corrected: Rescinded Temporary Increase in Arkansas Medicaid COVID-19 Vaccination Administration Rate – Effective May 5, 2023	4/21/2023	COVID-19
Procedure Code E8991 EP – Prior Authorization Required	4/7/2023	Procedure Codes
COVID-19 – New COVID-19 Vaccine Code 0174A	4/7/2023	COVID-19
XDEA Waivers Are No Longer Required as of 12/29/2022	4/6/2023	XDEA Waiver

OFFICIAL NOTICE – CORRECTED

TO: **Health Care Providers – All Providers**

DATE: **April 6, 2023**

SUBJECT: **XDEA Waivers Are No Longer Required as of 12/29/2022**

I. General Information

To align with the SAMHSA guidelines, Arkansas Department of Human Services will no longer require providers to have a XDEA Waiver on file as of 12/29/2022.

A retroactive claims analysis will be performed to identify and reprocess any claims that have improperly denied for XDEA nonconformance since 12/29/2022.

If you have questions regarding this notice, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211.If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 534-4138.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website.

Thank you for your participation in the Arkansas Medicaid Program.

Elizabeth Pitman
Director

OFFICIAL NOTICE – CORRECTED

TO: **Health Care Providers – All Providers**

DATE: **April 21, 2023**

SUBJECT: **RESCINDED Temporary Increase in Arkansas Medicaid COVID-19 Vaccination Administration Rate – Effective May 5, 2023**

I. General Information

Based on the continuing changing dynamics of the Federal Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) authorized Arkansas Medicaid to **rescind** the **temporary increase** in the reimbursement rate for administration of COVID-19 vaccines.

This temporary enhanced rate will be end dated to **May 5, 2023**.

The enhanced rate applied to administration of both first and second vaccinations (if Pfizer or Moderna), and a single administration of the Johnson & Johnson vaccination.

The OVERALL effective dates for the temporary vaccination administration rate increase are:

Beginning Date: Friday, August 13, 2021
Ending Date: Friday, May 05, 2023

All requirements, including but not limited to eligibility, procedure codes, providers, recordkeeping, and claims payment are contained in the DMS COVID-19 Provider Manual.

Any claims with date of service after May 5, 2023, will be paid at the pre-enhanced $40.00 rate.

If you have questions regarding this notice, please contact the Provider Assistance Center at

(800) 457-4454 toll-free or locally at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6428.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website.

Thank you for your participation in the Arkansas Medicaid Program.

Elizabeth Pitman
Director

Keeping You Informed

Public Health Emergency Unwind

Arkansas Medicaid appreciates providers' willingness to reach out to and connect with their Medicaid patients to ensure eligible beneficiaries keep their health care coverage. Providers have been and continue to be an integral part of Arkansas's outreach efforts during the unwinding from the Public Health Emergency. We have received a number of questions from providers during the unwinding and are sending this email to help answer those.

- Medicaid will continue to share with providers information on beneficiaries at risk of losing Medicaid eligibility and those who are up for renewal.
  - This information is provided in three ways.
    - Providers enrolled in the Patient-Centered Medical Homes (PCMH) program can access this information through the PITA tab of the monthly Population Health Management Report (PHMR), which is posted to the QCI portal on the 15th of each month.
    - Providers can request information from their AFMC Provider Representative.
    - Providers can also access this information through SHARE.
  - New Closure Category Column
    - This tab will identify why a patient lost coverage.
    - Failed to return Renewal form.
    - Failed to return the requested information.
    - Will also identify those who no longer are eligible.
    - Over income limit.
    - Requested closure.
    - No longer in the household.
- Medicaid does not provide a list of beneficiaries after disenrollment, but there are ways to identify those patients:
  - PCMHs can compare the monthly PHMR list.
  - Providers can compare the P200 report showing who they received PCCM payments for.
- Medicaid is aware of how this may affect PCMH minimum attributed attribution.
  - Those who fall off a PCMH panel before 6 months attributed will not be counted in Metrics.
  - Medicaid PCMH will review the effect that the PHE un-wind has on the PCMH program after the end of the calendar year.
  - Any additional concerns can be addressed during the PCMH reconsideration period.

As a reminder, there is a weekly Stakeholder meeting on Wednesday afternoons if a provider or practice wishes to participate. For invite information, feel free to reach out to your AFMC Provider Representative. ■

Provider Relations Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • **Transportation Helpline: 1-888-987-1200**

AFMC OUTREACH SPECIALISTS

Refer to the map and the color key below to find your representative.

Manager

Tabitha Kinggard **501-804-3277**
tkinggard@afmc.org

Supervisor, Provider Relations

Kellie Cornelius **501-804-2501**
kcornelius@afmc.org

Outreach Specialists

Emily Alexander..... **501-804-0184**
ealexander@afmc.org

Shawna Branscum.....**501-804-2373**
sbranscum@afmc.org

Kimberly Breedlove ...**501-553-7642**
kbreedlove@afmc.org

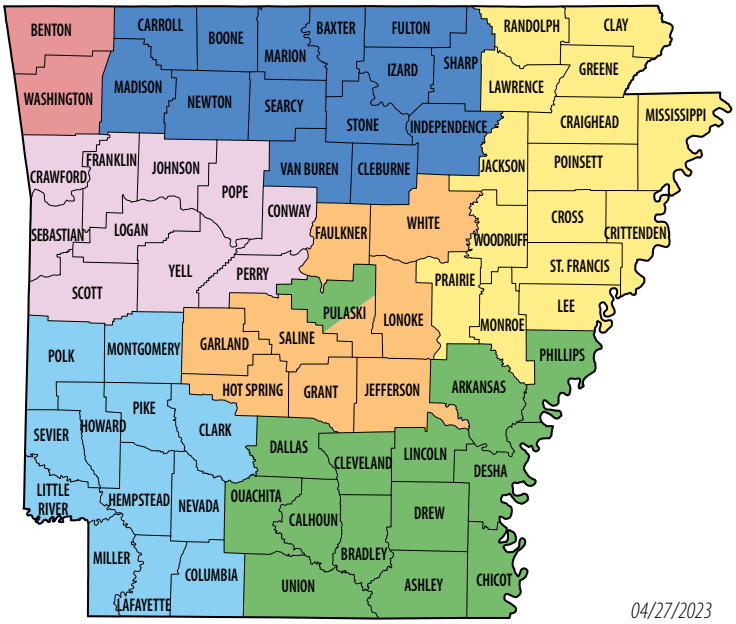
Jackie Clarkson.....**501-553-7665**
jclarkson@afmc.org

Carla Hestir.....**501-804-2901**
chestir@afmc.org

Connie Riley.....**501-545-7873**
criley@afmc.org

Supervisor, Outreach Logistics

Tonyia Long **501-212-8686**
tlong@afmc.org



04/27/2023

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

In-state toll free **800-457-4454**
Local & out-of-state **501-376-2211**
Gainwell Provider Services Manager
Cynthia Bogard..... **469-830-6768**

Gainwell Technologies Services

Provider Enrollment
P.O. Box 8105
Little Rock, AR 72203
Fax: **501-374-0746**

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

ARKIDS FIRST/MEDICAID MEDICAL ASSISTANCE

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**

VOICE RESPONSE SYSTEM
- Toll free **800-805-1512**

AFMC SERVICE CENTER (CLIENTS)
- Toll free **888-987-1200**

PCMH QUESTIONS.....**PCMH@afmc.org**

MAGELLAN MEDICAID ADMINISTRATION
- Pharmacy Help Desk.. **800-424-7895**
  Prescribers, Option 2

THIRD PARTY LIABILITY
- 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

IN THIS ISSUE OF ARMedicaid

ARKANSAS PHYSICIAN MEDICAID UPDATE

Q1 SFY2024
(July–September 2023)

- Managing AR Medicaid Beneficiary Caseload
- Providers – Keep Your Address and Email Information Up to Date
- Primary Care Providers – Region Selection
- Referrals – DMS-2610

Additional resources can be found at www.afmc.org/providerrelations

- Educational Outreach Updates
- PCP Update Packets/Archived PCP Update Packets
- Webinars

If you have any questions or if you would like additional information regarding any Medicaid topic, please contact the AFMC Provider Relations team:

- ProviderRelations@afmc.org
- 501-212-8686