ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

# ARKANSAS PHYSICIAN MEDICAID UPDATE

Q1 SFY 2025
(July–September 2024)

## What's New for Arkansas Medicaid Providers

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

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# Out of State Services for AR Medicaid Beneficiaries

If an Arkansas Medicaid covered service can't be provided in-state or PCP Instate and Trade-Area Restriction and PCP for Out-of-State Services, the Primary Care Provider (PCP) must receive permission from the Arkansas Division of Medical Services Utilization Review Section before referring the beneficiary to an out-of-state provider. The Utilization Review Section will tell the PCP what medical documentation is needed to consider the request for out-of-state treatment. The out-of-state facility and/or provider(s) must be credentialed as an Arkansas Medicaid provider to provide and be reimbursed for services.

In addition to receiving permission for out-of-state treatment, the out-of-state provider must request prior authorization before treatment, if it is required.

Utilization Review's contact information:

Arkansas DHS, Division of Medical Services, Utilization Review Section

Toll free (800) 482-5850, extension 2-8340

Telephone (501) 682-8340

Prospective Arkansas Medicaid providers can access the online enrollment form using this web link - https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/

Enrollment questions should be directed to Gainwell Provider Enrollment @ (501) 376-2211.

To request a prior authorization if one is needed, the out-of-state provider will do so using the Medicaid MMIS portal. The MMIS prior authorization job aid walks you through the steps of requesting a prior authorization - https://humanservices.arkansas.gov/wp-content/uploads/MMIS_JobAid_PriorAuthorization.pdf ■

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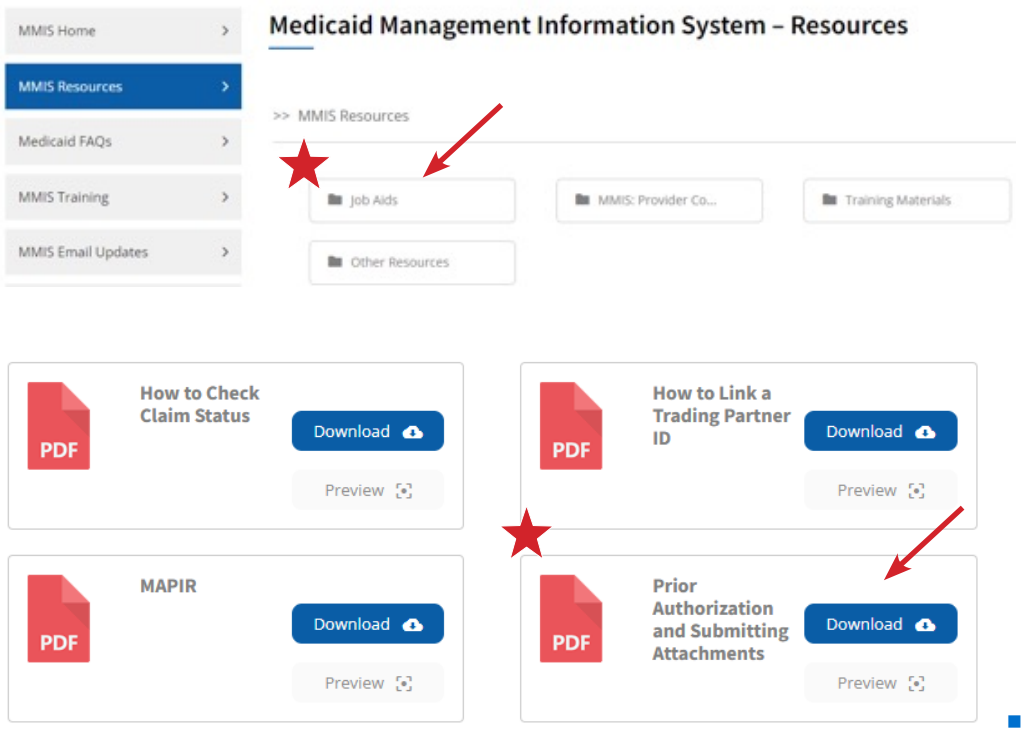
# Prior Authorization Process and Frequently Asked Questions

Arkansas Medicaid requires that certain medical and surgical procedures be authorized by DHS or its designated vendor prior to the performance of the procedure. Procedures can require prior authorization regardless of whether they are performed on an inpatient or outpatient basis. Procedures that require prior authorization can be found in section II of your Arkansas Medicaid Provider Manual or on the procedure code table for your provider type. Providers are encouraged to utilize the preferred method of submitting electronic requests through the web-based portal, Medicaid Information Management Systems (MMIS). The portal allows providers to submit a Prior Authorization (PA) request, view the status of authorizations, and request a reconsideration if your prior authorization is denied, approved with modifications, or partially approved. A PA reconsideration can only be submitted once, so please make sure the correct documentation or information is included or attached for the reconsideration process.

AFMC has a job aid resource tool that provides step-by-step instructions on how to create a PA request, check the status, and how to request a reconsideration through the Medicaid portal. To access the Prior Authorization and Submitting Attachments job aid, please visit the AFMC MMIS resource page - https://medicaid.afmc.org/mmis-resources.



# Prior Authorization Frequently Asked Questions

## Whom Should I Call for Prior Authorizations (PAs)?

Where you obtain PAs depends both on the type of PA and the beneficiary's age. You will find contact information for each type of PA on the MMIS Health Care Provider Portal (log on, select the Care Management tab and then Authorizations).

Some PAs can be requested through the Health Care Provider Portal (log on and select Care Management), while others are processed through Medicaid contractors such as AFMC or Acentra Health. If you request your PA type through Acentra Health or AFMC, use the instructions in Section II of your provider manual for requesting PAs.

The MMIS Health Care Provider Portal requires providers to select a process type upon the initial request for prior authorization. This allows the prior authorization request to be systematically sent to the correct area for review and decision.

**The following PA types are available on the portal:**

- 101 – Personal Care
- 102 – Private Duty Nursing
- 103 – Adult Dental
- 104 – Child Dental
- 105 – Orthodontics
- 107 – Hearing Services
- 108 – Augmentative Communication Device Evaluation
- 109 – Disposable Medical Supplies
- 110 – Home Health Visit Extensions
- 111 – Other prosthetics
- 112 – Other medical service
- 114 – Specialized Service
- 115 – Independent Choices
- 116 – Vision
- 150 – DDS/ACS waiver
- 151 – DDS services
- 152 – Developmental Rehab Services
- 153 – Title V154 – First Connections

## How Can I Track A PA Request?

Each Prior Authorization request will have a unique, numeric identifier. This number will be assigned by the MMIS portal when the PA request is created for all media types.

## How Long Will I Be Able to See My PA Requests on The Health Care Provider Portal?

All PAs can be viewed on the Health Care Provider Portal for up to three years.

## I Submitted A PA Request but I Need to Make a Change. Can I Edit the Request on The Health Care Provider Portal?

No. Prior Authorization requests cannot be edited or changed after clicking the "Submit" button. Please ensure the required fields are completed appropriately. Once the "Submit" button is selected, no further edits can be made to any fields. If changes are required after the "Submit" button is selected, you must call the State Analyst to void the incorrect PA request and then resubmit a new PA request.

## Does The Health Care Provider Portal Alert Me When a Procedure Requires Prior Authorization?

Providers will have to refer to the provider manual to determine if a code requires a prior authorization. The Health Care Provider Portal does not provide this information. ■

# Inspire Your Beneficiaries to Take Control of Their Diabetes

**AFMC's Medicaid Quality Improvement (MQI) team in collaboration with Arkansas Medicaid** is offering free Diabetes Empowerment Education Program (DEEP™) workshops to Medicaid and/or dual eligible adult beneficiaries with Type 2 Diabetes.

**Workshops are currently being offered in Faulkner, Johnson, Calhoun, Ouachita, and Union counties.**

**DEEP™** is a Diabetes Self-Management Education (DSME) Program that motivates and empowers adults with diabetes to build skills and make small changes to help them live longer, healthier lives. DEEP™ was developed at the University of Illinois at Chicago. The curriculum is designed to engage participants in self-management practices for the prevention and control of diabetes. This is a very interactive and fun program!

**DEEP™ community workshops are held once a week for six weeks and cover eight modules. Each workshop lasts 1.5 hours.**

**Contact** mqi@afmc.org **for more information.** ■

# Vaccine Counseling for EPSDT Members

The Arkansas Department of Human Services added coverage for procedure codes G0312 EP and G0315 EP effective 4/1/2024. This will align with CMS guidance to cover stand-alone vaccination counseling in the EPSDT Program. A total of four (4) Vaccine Counseling Sessions (G0312 EP or G0315 EP) may be billed per State Fiscal Year (SFY). And extension of benefits under Process Type 126 – Professional Services can be obtained through the MMIS Provider Portal and will be reviewed by the Arkansas Foundation for Medical Care (AFMC). The following procedure codes are effective 4/1/2024 under the Medical Services (MEDSV) and Nurse Practitioner (NURSP) Contracts:

| Proc Code | Description | Mod | Provider Contract | Age Limits |
|---|---|---|---|---|
| G0312 | IMMUNIZE COUNS < 21YR 5-15 M | EP | MEDSV & NURSP | 0-20 yrs |
| G0315 | COUNSEL IMMUNE < 21YR 5-15 M | EP | MEDSV & NURSP | 0-20 yrs |

If providers counsel on a specific vaccine and it is not given the day education is provided, providers can bill a counseling service code for the vaccine that was not provided. Example: The provider counsels on four vaccines but only three are given. The provider can bill for vaccine counseling for the one that was not given. Providers should document in the beneficiary's record to support the education provided and beneficiary's decision to decline the vaccine. ■

# Behavioral Health Integration in a Primary Care Setting

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

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

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

A. The person who is performing the covered service must be either of the following:
   1. A paid employee of the physician who is billing the Medicaid Program. A W-4 must be on file in the physician's office; or
   2. A subcontractor of the physician who is billing the Medicaid Program. A contract between the physician and the subcontractor must be on file in the physician's office;

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

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

C. Psychological testing is not covered, except as defined in the Arkansas Medicaid **Diagnostic and Evaluation Manual** – https://humanservices.arkansas.gov/wp-content/uploads/DIAGEVAL_II.doc
   Refer to Section 292.740 of this manual for more information.

**How do I enroll as an AR Medicaid provider?**

Visit https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/ for video instructions on how to complete your application, what documents are required for your specialty type, and who can enroll under each group type.

**What does it mean for Behavioral Health providers to be integrated with a Primary Care Provider (PCP)?**

- The Behavioral Health provider is an employee of the PCP practice.
  - The Behavioral Health provider is affiliated with the practice by completing the "**Section IV - Provider Group Affiliation Form**" found here: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/
- Documentation for services is completed in the PCP's EHR or the beneficiary's medical record.
  - Resources
    - HHS.gov Guidance and FAQ HIPAA Privacy Rule and Sharing Information Related to Mental Health https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html?language=es
    - OCR guidance and fact sheet -Disclosures to family members and friends https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/coveredentities/provider_ffg.pdf
- The PCP practice handles appointment scheduling and administrative logistics for services provided.
- The PCP practice bills for the services performed by the Behavioral Health provider.

**Can Behavioral Health services be provided in a PCP setting without affiliation?**

- Yes, the PCP and Behavioral Health provider can co-locate.

**What is meant by co-location?**

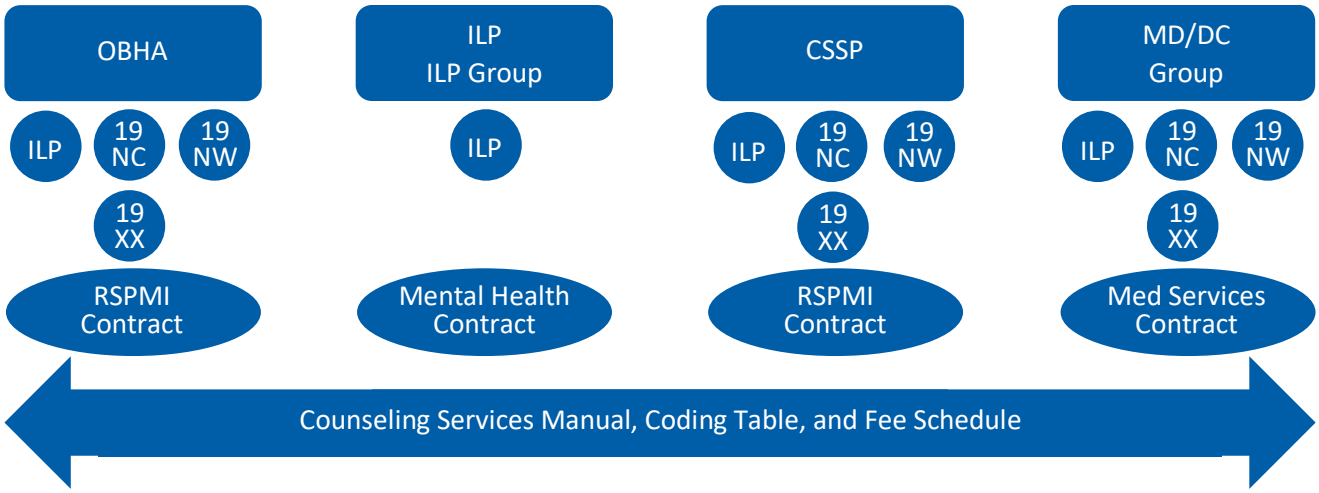
Co-location refers to services that are in the same physical space, though not necessarily fully integrated with one another.

- The agreement is between the PCP's office and Behavioral Health provider for space to provide services – no credentialing affiliation is required.
- The Behavioral Health provider bills for services provided.
- Behavioral Health services are provided in a PCP setting.
- Documentation for services is completed in the Behavioral Health provider's EHR, or the beneficiary's medical record.

**What AR Medicaid manual do I reference for counseling services?**

- **Counseling Services** – https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/cnslserv-prov/
- **Counseling Services Procedure Code Table** – https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/proc-codes/
- **Counseling Services Fee Schedule** – https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/

**Who can bill for Behavioral Health Services?**




**Independently Licensed Practitioner (ILP) - Independently Licensed as a Provider Type/Provider Specialty**

- Licensed Clinical Certified Social Worker (LCSW) 19/WI
- Licensed Marital and Family Therapist (LMFT) 19/R5
- Licensed Psychologist (LP) 19/62
- Licensed Psychological Examiner – Independent (LPEI) 19/62
- Licensed Professional Counselor (LPC) 19/W2
- Licensed Alcohol and Drug Abuse Counselor (LADAC) 19/RD

**Non-Independently Licensed Practitioner (ILP) Providers**

- Non-ILP – LPC, LCSW, LMFT (19/NC)
- Non-ILP – LPE-I, LPE, LP (NC/XX)

**Registered Non-Credentialed Providers**

- Master's Level Clinicians (95/NW)

**Helpful tips:**

- ILPs can provide services in multiple practices.
    - An ILP can be affiliated with more than one practice and provide services to both locations (e.g., MW – Dr. Jones and TTH – Dr. Smith). This scenario would need to be shared with the PCP practices for scheduling purposes. Also, the ILP would receive payment from each PCP practice, as they are employees of each. Each practice would bill for their services provided.
- An ILP can be co-located with multiple practices. In this scenario, the ILP would provide services and bill themselves for each visit.
    - ILPs can also have their own practice (outside of the integrated/co-location services provided) should beneficiaries want to be seen in a different location.

**Who can refer a beneficiary for an Independent Assessment if the beneficiary is receiving counseling services but not responding to treatment?**

- PCPs and Behavioral Health service providers who identify that a beneficiary may require services in addition to behavioral health counseling services and medication management (including mental health and substance abuse residential treatment) may transmit a request for the assessment to Acentra, the AR Medicaid Quality Improvement Organization vendor, via the portal. Click on the following link to complete the electronic registration portal form – https://arwebportal.eqhs.com/providerportal/providerregistration.aspx/Arkansas.

# Magellan – AR Medicaid Contracted Pharmacy Vendor

Magellan is the DHS contracted pharmacy vendor. The latest forms, pharmacy memorandums, prescription drug information, provider documents, guidelines, and reports can be viewed and downloaded at https://ar.magellanrx.com/.

- Magellan Pharmacy/PDL Call Center: (800) 424-7895
  - Pharmacy Support — Speak "Pharmacy"
  - Prescriber Support — Speak "Prescriber"
  - Beneficiary Support — Speak "Member"
  - Web Support — Speak "Prescriber" or "Pharmacy," then speak "Web Support"
- Magellan Fax Number: (800) 424-7976
- PDL Fax Number: (800) 424-5739
- Call Center hours are Monday — Friday 8AM — 5PM CST excluding state holidays.
- Web Support hours are Monday — Friday 7AM — 7PM CST.

## Where May I See a List of the Drugs Covered by the Arkansas Medicaid Program?

Arkansas Medicaid provides guidelines for determining what products are payable. Coverage of any product depends on the manufacturer's or labeler's participation in the federal rebate program administered by the Centers for Medicare and Medicaid Services. The Arkansas Medicaid Pharmacy provider manual defines the scope of coverage in Section II.

More prescription drug information can be found at the Magellan Medicaid Administration website.

## Monthly Prescription Limits – Section II – AR Medicaid Pharmacy Manual

**213.100 Monthly Prescription Limits 2-1-24**

A. Each prescription for all Medicaid-eligible clients may be filled for up to a maximum thirty-one-day supply. Maintenance medications for chronic illnesses must be prescribed and dispensed in quantities sufficient (not to exceed the maximum thirty-one-day supply per prescription) to effect optimum economy in dispensing. For drugs that are specially packaged for therapy exceeding thirty-one (31) days, the days' supply limit (other than thirty-one (31)), as approved by the agency, will be allowed for claims processing. Contact the Pharmacy Help Desk to inquire about specific days' supply limits on specially packaged dosage units.

View or print the contact information for the DHS contracted Pharmacy vendor.

B. Each Medicaid-eligible client twenty-one (21) years of age and older is limited to six (6) Medicaid-paid prescriptions per calendar month.

Each prescription filled counts toward the monthly prescription limit except for the following:

1. Family planning items. Including without limitation, birth control pills, contraceptive foams, contraceptive sponges, suppositories, jellies, prophylactics, and diaphragms;

2. Prescriptions for Medicaid-eligible long-term care facility residents(must be for Medicaid-covered drugs);
3. Prescriptions for Medicaid-eligible clients under twenty-one (21) years of age in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. (must be for Medicaid-covered drugs);
4. Prescriptions for opioid or alcohol use disorder treatment;
5. Prescriptions for tobacco cessation products;
6. Prescriptions for the treatment of high blood pressure;
7. Prescriptions for the treatment of hypercholesterolemia;
8. Blood modifier medications;
9. Prescriptions for the treatment of diabetes; and
10. Inhalers to treat respiratory illness.

C. Living Choices Assisted Living Program clients are eligible for up to nine (9) medically necessary prescriptions per month.

D. After the client has received the maximum monthly benefit or the maximum monthly extended benefit, they will be responsible for paying for their own medications for the remainder of the month. ■

# Upcoming Continuous Glucose Monitor and Diabetic Supplies Billing Update

As previously communicated, Arkansas Medicaid is updating the billing processes for diabetic supplies including Continuous Glucose Monitors (CGMs), which will be changing to a pharmacy claim type submission by both pharmacies and DME providers. **The official start date is 8/1/2024 for both DME providers and pharmacy providers.**

Beginning **July 1, 2024**, DME providers who manage diabetic supplies including CGMs may register for the new billing portal by logging into the DHS Pharmacy website managed by Prime Therapeutics/Magellan, at https://ar.magellanrx.com. To complete online registration, the DME provider will click on the Login icon in the upper right corner of the screen, then click on Provider, and click Register. This will generate a PIN, which is mailed to a physical address. A registration guide for the web portal is available at https://ar.magellanrx.com/documents/d/arkansas/arkansas-medicaid-rx-uac-quick-start-guide. If there are login issues to the portal, the Magellan Call Center has a web support option in the regular Help Desk phone tree at (800) 424-7895, where callers can be transferred to that center. Providers can also reach Web Support directly at (800) 241-8726 for help with portal login issues. A user guide is posted for the new DME web claim submissions, found at https://ar.magellanrx.com/documents/d/arkansas/arkansas-medicaid-rx-web-claims-submission-user-guide and does not require a login. Training will be provided for the new DME provider billing portal, with more specifics announced soon.

Pharmacies billing NCPDP claims may begin to bill for the diabetic supplies as regular prescriptions on August 1, 2024. Diabetic supplies may be billed with a prescription for children and adults. For adults, the diabetic supplies will not count towards prescription limits.

Please visit the DHS Pharmacy website managed by Prime Therapeutics/Magellan at http://ar.magellanrx.com, and see the drop-down Resources tab for all diabetic supply announcements and criteria, including web portal submissions guidance. Registration is not needed to view this information. The Magellan Help Desk can be reached Monday through Friday, from 8:00 am to 5:00 pm, at (800) 424-7895. ■

# Credentialing Changes for Physician Assistants

Important news regarding changes to the application process for Provider Type (PT 12) Specialty NV.

1. **Beginning April 1, 2024**, Physician Assistants (PAs) could submit an application under the new **Provider Type 12 Specialty NV**.
2. **Effective July 1, 2024**, all PAs must have an active **PT 12** for claims submissions. Please ensure that you apply for PT 12 promptly to avoid any disruptions in claims processing.
3. **Application Submission Options:** You can submit your PT 12 application through the **AR Medicaid enrollment portal**.
4. **Deactivation**: All active **PT 95 specialty NV numbers** will be **deactivated** on **July 1, 2024**. To continue providing services, make sure you have an active PT 12 Specialty NV Medicaid ID.
5. **Revalidation Every 5 Years:** The conversion from PT 95 to PT 12 requires providers to revalidate their status every 5 years. This ensures compliance and maintains accurate records.
6. **Direct Billing Capability**: PT 12 allows for certain billings to be submitted directly or as a rendering provider.
7. **Start Your Application Electronically**: Use this link to begin your application electronically. Completing your submission through the portal makes it easy for you to have online access to your application status and helps collect all necessary information for efficient processing.

Enrollment Application: Initiate a New Enrollment application.

Resume Enrollment: Resume an existing application that you previously started or respond to an RTP. "Return To Provider"

Enrollment Status: Check the status of an enrollment application.

If you have any questions or need assistance, please don't hesitate to reach out to the Gainwell provider help desk at 1-800-457-4454. ■

# Voice Response System (VRS)

The Voice Response System (VRS) is an automated phone system used to assign a Primary Care Provider (PCP) for AR Medicaid beneficiaries. This feature can only be used by PCP offices and hospitals. The VRS will only assign a PCP effective on the date the PCP assignment is made, it cannot process backdated assignments. The VRS phone number is 800-805-1512.

Enrollment through the VRS is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS. 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.

AR Medicaid requires the beneficiary to complete the DMS-2609 Primary Care Provider and Change form prior to PCP assignment through the VRS. The PCP practice and hospital must maintain a copy of the form in the beneficiary's file. A copy can be provided to the beneficiary upon request. In addition to maintaining a copy in their personal file, hospitals are required to provide a copy of the completed form to the assigned PCP. This process informs the assigned PCP allowing for follow-up outreach and establishment of care. Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with a PCP. Hospitals should use revenue Code 960 on their claim for enrollment fee reimbursement.

If the hospital follows this process for PCP assignment, a referral is not required for non-emergent services on the effective date or on the day after the effective date of PCP assignment. Policy reference section 172.100 – letter T.

### 173.200 PCP Selection and Enrollment at PCP Offices and Clinics 10-8-10

A. Enrollees must document their PCP choice on a Primary Care Physician Selection and Change form (DMS 2609 or DCO-2609.)

1. The form must be completed, dated and signed by the enrollee.
2. The enrollee may request and receive a copy of the form.
3. The PCP office must retain a copy of the form in the enrollee's file.

B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. View or print Voice Response System (VRS) contact information.

C. When a PCP wants to add a new enrollee but the PCP's Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:

1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the Medicaid website https://medicaid.mmis.arkansas.gov/ Provider Enrollment Information, Access to the Provider Information Portal.
2. Prior to making the request for an increase of a caseload that is already at maximum, the PCP is encouraged to review their caseload using the AMII (Arkansas Medicaid Information Interchange) web portal for inactive patients, to determine if those patients should be removed from their caseload. An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. View or print Provider Relations Representative contact information.

### 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. ■

# Alternative Benefit Plan

There are 2 Medicaid Expansion Alternative Benefit Plan (ABP) aid categories – 06-ABP and 06-IABP (Interim Alternative Benefit Plan). Both plans have unlimited physician visit benefit limits, unlimited lab and radiology benefit limits, and unlimited pharmacy benefit limits. The 06-ABP plan requires a PCP assignment and the 06-IABP plan does not require a PCP assignment. The 06-IABP plan is used while the beneficiary's Medicaid Expansion plan determination is finalized and when finalized, the beneficiary will either go into the 06-Medicaid Frail plan or one of the 06-ARHOME plans (Ambetter or Arkansas BCBS). Traditional Medicaid services not covered under both Alternative Benefit Plans are personal care, long term care, and Medicaid home and community-based services.

If a Medicaid Frail beneficiary needs to change their plan to the Alternative Benefit Plan (ABP), they must call the AFMC Call Center (1-888-987-1200) and it will go into effect the first day of the following month. ■

# Messages for AR Medicaid Providers

**Messages for Remittance Advices dated June 20, 2024 –June 27, 2024**

**TO: PROSTHETICS PROVIDERS** **RE: UPCOMING CONTINUOUS GLUCOSE MONITOR AND DIABETIC SUPPLIES TRAINING UPDATE**

As previously communicated, Arkansas Medicaid is updating the billing processes for diabetic supplies including Continuous Glucose Monitors (CGMs), which will be changing to a pharmacy claim type submission by both pharmacies and DME providers. The official start date is 8/1/2024 for both DME providers and pharmacy providers. For DME providers, dates for the new portal training sessions have been set. The exact times and links will be provided in the next few days. The training dates are July 2nd in the am, July 3rd in the am, and two sessions on July 9th, one in the am and one in the pm.

**Messages for Remittance Advices dated June 13, 2024 –June 20, 2024**

**TO: ALL PROVIDERS** **RE: FEDERAL ORDERING, REFERRING, RENDERING, AND PRESCRIBING (ORP) REQUIREMENTS**

There was a recent MMIS change implemented to bring the system into compliance with federal ordering, referring, rendering, and prescribing (ORP) requirements, which require a referring and ordering provider to be listed on Medicaid claims (See 42 CFR § 455.440). This affects providers who deliver Audiology, Hearing, Laboratory, Radiology, or Therapy services. If you receive EOB code 1228 "ORDERING PROVIDER IS REQUIRED FOR THE SERVICE," you must enter the ordering provider on your claim. For instructions on how to enter the ordering provider on a claim in the Health Care Portal, please see the Job Aid: https://humanservices.arkansas.gov/wp-content/uploads/MMIS_JobAid_SubmittingReviewingClaim.pdf.

For instructions regarding how to bill a crossover claim in the Healthcare Portal, please see the Quick Track Training Guide: https://humanservices.arkansas.gov/wp-content/uploads/HowtoSubmitMed_icare_icaidClaim.pdf

Please contact your MMIS Outreach Specialist for further assistance with keying claims in the Healthcare Portal: https://medicaid.afmc.org/images/MMIS_OutreachSpecialistsMap_Updated_20230424_v10.pdf

**Messages for Remittance Advices dated May 23, 2024 –May 30, 2024**

**TO: PHYSICIAN, HOSPITAL, SKILLED NURSING FACILITY, PROSTHETICS, AMBULATORY SURGICAL CENTER, RURAL HEALTH CLINIC, NURSE PRACTITIONER, AND BEHAVIORAL, MENTAL, PSYCHOLOGICAL GROUP PROVIDERS** **RE: EDIT 3383 RETROSPECTIVE EOMB REVIEW**

Certain claims previously recouped under the 3383 Retrospective Review will be reprocessed when the EOMB was reviewed and determined to be correct prior to initial recoupment.

Moving forward, EOMBs will not be reviewed if not received within the timeframe specified on the audit letters sent to providers.

Providers should refer to instructions on the most recent audit letter received.

**TO: ALL PROVIDERS** **RE: NCCI INPATIENT ONLY CHANGES / PLACE OF SERVICE (POS) DENIALS**

In November of 2023 changes went in the system with the CMS NCCI Inpatient Only procedure codes that made changes back to 1/1/2022. However, NCCI had retro-activated some of these codes and removed them from the NCCI Inpatient Only list. The system has now been updated to align with the NCCI policy. The appropriate POS has been updated on these procedure codes. Arkansas Department of Human Services will review impacted claims and perform Mass Adjustments as quickly as possible.

**TO: HOSPITAL PROVIDER** **RE: CORRECTION TO GROUP 5080 WITH MISSING HCPCS PROCEDURE CODES**

There were claims paid in error due to missing procedure codes in group 5080: J0206, J1805, J1806, J1812, J1814, J1920, J1921, J2249, J2305, J2329, J2371, J2372, J2427, J2598, J2599, J7213, J9029, J9056, J9058, J9059, J9259, J9322, J9323, and Q5131. Those paid claims will be recouped. You do not need to take any action at this time. The recoupments will take place after May 23, 2024.

**TO: PHYSICIAN AND NURSE PRACTITIONER PROVIDERS** **RE: COUNSELING SERVICES PARENT SCREENINGS**

As of 01/01/2023 a physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening billed under the minor's Medicaid number.

**TO: REGISTERED, NON-CREDENTIALED PROVIDERS** **RE: PHYSICIAN ASSISTANTS REGARDING CHANGE TO MEDICAID ENROLLMENT**

Important Information for Physician Assistants regarding change to Medicaid Enrollment. Action is required on your part before July 1, 2024. Please read the following information carefully:

1. Effective Date: Starting April 1, 2024, Physician Assistants (PAs) will be able to submit applications under the new Provider Type 12 Specialty NV.

2. Billing Transition Period: Until July 1, 2024, PAs should continue to bill using the current PT 95 NV for services provided. During this transition period, it's essential to follow the existing billing procedures.

3. Mandatory PT 12 After July 1, 2024: After July 1, 2024, all PAs must have an active PT 12 for claims submissions. Please ensure that you apply for PT 12 promptly to avoid any disruptions in claims processing.

4. Application Submission Options: You can submit your PT 12 application through the AR Medicaid enrollment portal.

5. Deactivation of PT 95 Numbers: All active PT 95 specialty NV numbers will be deactivated on July 1, 2024. To continue providing services, make sure you have an active PT 12 Specialty NV Medicaid ID.

6. Revalidation Every 5 Years: The conversion from PT 95 to PT 12 requires providers to revalidate their status every 5 years. This ensures compliance and maintains accurate records.

7. Direct Billing Capability: PT 12 allows for certain billings to be submitted directly or as a rendering provider.

If you have any questions or need assistance, please call 1-800-457-4454.

# What's New for Arkansas Medicaid Providers

Official notices posted from April 1, 2024 – June 30, 2024. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

| Title | Posted Date | Category |
|---|---|---|
| Vaccine Counseling for EPSDT Members | 4/1/2024 | Procedural Codes |
| Billing for Triage, Treat, and Transport (ET3) – REVISED | 4/4/2024 | Procedure Codes |
| Coverage for 99205 U2 | 4/5/2024 | Procedure Codes |
| Rate Change for Procedure Code 49082 | 4/10/2024 | Procedure Codes |
| Coverage Added for Procedure Codes 49082, 95145, and 95165 | 4/15/2024 | Procedure Codes |
| Upcoming continuous Glucose Monitor and Diabetic Supplies Billing Update | 4/25/2024 | Billing Instruction |
| 2024 Quarter 2 Healthcare Common Procedure Coding System Level II (HCPCS) Code & Current Procedural Terminology (CPT) Code Conversion | 5/1/2024 | Procedure Codes |
| Coverage Added for Procedure Code 99239 | 5/17/2024 | Procedure Codes |
| Prior Authorization (PA) Required for Procedure Codes 76981-76983 | 5/23/2024 | Procedure Codes |
| Extension for Hyperalimentation Prior Authorization (PA) if Member's Condition is Chronic | 6/4/2024 | Prior Authorization |
| Coverage Added for Procedure Codes 93226, 93243, and 93247 | 6/10/2024 | Procedure Codes |
| Coverage Added for New COVID Codes M0224 and Q0224 | 6/10/2024 | Procedure Codes |
| Upcoming Continuous Glucose Monitor and Diabetic Supplies Billing Update | 6/11/2024 | Billing Instruction |
| Coverage Added for Procedure Code 10061 | 6/14/2024 | Procedure Codes |
| Upcoming Continuous Glucose Monitor and Diabetes Supplies Training Update | 6/20/2024 | Training |

**TO:** **Health Care Providers – Nurse Practitioner and Physician**
**DATE:** **April 1-2024**
**SUBJECT:** **Vaccine Counseling for EPSDT Members**

## I. General Information

Arkansas Department of Human Services added coverage for procedure codes G0312 EP and G0315 EP effective 4/1/2024. This will align with CMS guidance to cover stand-alone vaccination counseling in the EPSDT Program.

A total of four (4) Vaccine Counseling sessions (G0312 EP or G0315 EP) may be billed per State Fiscal Year (SFY). An extension of benefits (under Process Type 126 – Professional Services) can be obtained through the Provider Portal and will be reviewed by Arkansas Foundation for Medical Care (AFMC).

## II. Procedure Codes

The following procedure codes are effective 4/1/2024 under the Medical Services (MEDSV) and Nurse Practitioner (NURSP) Contracts:

| Proc Code | Description | Mod | Provider Contract | Age Limits |
|---|---|---|---|---|
| G0312 | IMMUNIZE COUNS < 21YR 5-15 M | EP | MEDSV & NURSP | 0-20 yrs |
| G0315 | COUNSEL IMMUNE < 21YR 5-15 M | EP | MEDSV & NURSP | 0-20 yrs |

## III. Contact Information for Obtaining Extension of Benefits

When obtaining a Prior Authorization from the Arkansas Foundation for Medical Care (AFMC) please send your request to the following:

| **Arkansas Foundation for Medical Care** | |
|---|---|
| In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only | 1-800-426-2234 |
| General telephone contact, local or long distance – Fort Smith | (479) 649-8501<br>1-877-650-2362 (toll free) |
| Fax for Molecular Pathology only | (479)-649-0799 |
| Fax – General | (479) 649-0799 |
| Fax – Physician Drug Reviews Only (PDR) | (479)-649-0799 |
| Mailing address | **Arkansas Foundation for Medical Care, Inc.**<br>P.O. Box 1508<br>Fort Smith, AR 72902 |
| Physical site location | 1101 South 21st Street<br>Fort Smith, AR 72901 |
| Office hours | 8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays |
| Web portal – AFMC | https://reviewpoint.afmc.org/s/login/ |
| Web portal – Arkansas Medicaid | https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx |

**TO:** **Health Care Providers – Nurse Practitioner**
**DATE:** **April 5, 2024**
**SUBJECT:** **Coverage for 99205 U2**

**I. General Information**

Arkansas Department of Human Services added coverage for procedure code 99205 U2 effective 4/1/2024.

**II. Procedure Codes**

The following procedure code is effective 4/1/2024 under the Nurse Practitioner (NURSP) Contract:

| Proc Code | Description | Mod | Age |
|---|---|---|---|
| 99205 | SEXUAL ABUSE EXAMINATION | U2 | 0-20 yrs |

**TO:** **Health Care Providers – Nurse Practitioner**
**DATE:** **April 15, 2024**
**SUBJECT:** **Coverage Added for Procedure Codes 49082, 95145, and 95165**

**I. General Information**

Arkansas Department of Human Services added coverage for procedure codes 49082, 95145, and 95165 effective retroactively to 4/1/2023.

Claims analysis will be performed to identify and reprocess any claims that may have been processed prior to coverage being added in system.

**II. Procedure Codes**

The following procedure codes are effective retroactively to 4/1/2023 under the Nurse Practitioner (NURSP) Contract:

| Proc Code | Description | Contract | Age |
|---|---|---|---|
| 49082 | ABD PARACENTESIS | NURSP | |
| 95145 | ANTIGEN THERAPY SERVICES | NURSP | 0-20 yrs |
| 95165 | ANTIGEN THERAPY SERVICES | NURSP | 0-20 yrs |

**TO:** **Health Care Providers – Nurse Practitioner**
**DATE:** **June 14, 2024**
**SUBJECT:** **Coverage Added for Procedure Code 10061**

**I. General Information**

Arkansas Department of Human Services has added coverage for procedure code 10061 under the Nurse Practitioner Contract.

Claims analysis will be performed to identify and reprocess any claims that may have been processed prior to coverage being added in system.

**II. Procedure Codes**

The following procedure codes are effective retroactively to 6/1/2023:

| Proc Code | Description | Provider Contract |
|---|---|---|
| 10061 | I&D ABSCESS COMP/MULTIPLE | NURSP |

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ARKANSAS ACEs & RESILIENCE COALITION


# REGISTRATION IS OPEN!

## 8th Annual ACEs and Resilience Summit

## August 8

### Benton Event Center / Benton, AR

**REGISTER NOW**

**Attend In-person ($50) or Virtually ($40)**

This year, ACEs Summit promises to be better than ever. You won't want to miss a moment, so get your tickets today. We look forward to welcoming you to ACEs Summit 24!

# 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, Outreach Services*

**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

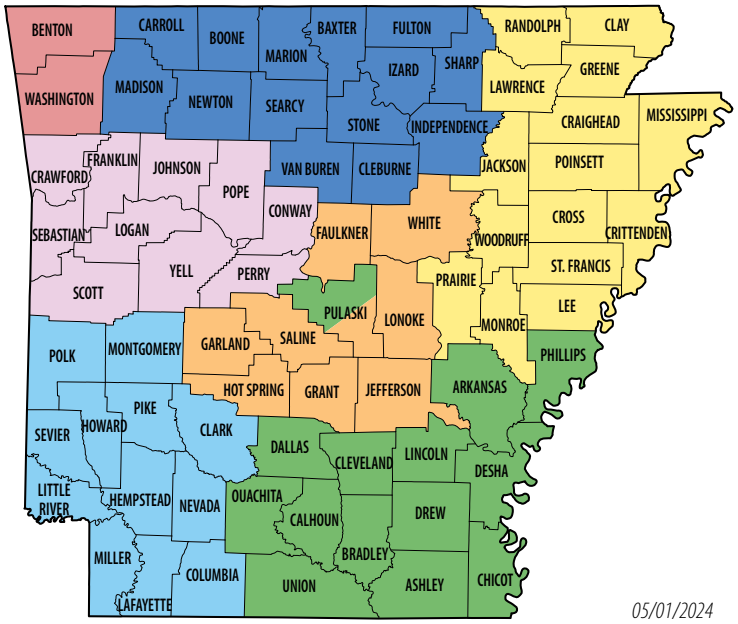
**Jackie Clarkson**.....**501-553-7665**
jclarkson@afmc.org

**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




*05/01/2024*

## 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**
Tyler Brickey ..... **501-590-6325**

### *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

### CONNECTCARE - BENEFICIARY SERVICES

- Complaints
- Demographic updates
- Eligibility/Medicaid coverage/ Medicaid card
- Find a doctor/PCP assignment
- Other resources

• Toll free ..... **800-275-1131**

### MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

• Central Arkansas..... **501-682-8349**

### VOICE RESPONSE SYSTEM - PCP ASSIGNMENT

• Toll free ..... **800-805-1512**

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

### MAGELLAN MEDICAID ADMINISTRATION

• Pharmacy Help Desk.. **800-424-7895**

### 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 SFY 2025
(July–September 2024)

- Alternative Benefit Plan (ABP)
- Credentialing Changes for Physician Assistants
- Diabetes Empowerment Education Program (DEEP)
- Magellan – AR Medicaid Pharmacy Vendor
- Out-of-State Services for AR Medicaid Beneficiaries
- Prior Authorization Process and FAQs
- Process for Behavioral Health Integration in PCP Setting
- Vaccine Counseling for EPSDT Members

**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