ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PROVIDER MEDICAID UPDATE

Q1 SFY 2026
(July–September 2025)

What's New for Arkansas Medicaid Providers

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

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Presumptive Eligibility for Pregnant Women (PE-PW) – New AR Medicaid Benefit Plan

Presumptive Eligibility for Pregnant Women is a Medicaid health care program that allows pregnant women who are likely to be eligible for regular Medicaid health care to receive prenatal care for a limited time without having to go through the full application process before seeking care.

A recorded webinar about the new AR Medicaid benefit plan can be reviewed at https://medicaid.afmc.org/provider-relations-policy-education/webinars.

For more information on Presumptive Eligibility, including a brochure with resources for beneficiaries, visit the Arkansas Department of Human Services website: Presumptive Eligibility for Pregnant Women (PE-PW).

Official Notice

TO: Health Care Providers – All Providers

DATE: June 16, 2025, Revised July 2, 2025

SUBJECT: New Coverage - Presumptive Eligibility – Pregnant Women (PE-PW)

I. General Information

On July 1, 2025, and effective for dates of service on or after June 1, 2025, the Department of Humans Services (DHS) is adding presumptive eligibility for pregnant women under Medicaid, pursuant to Acts 124 and 140 of 2025.

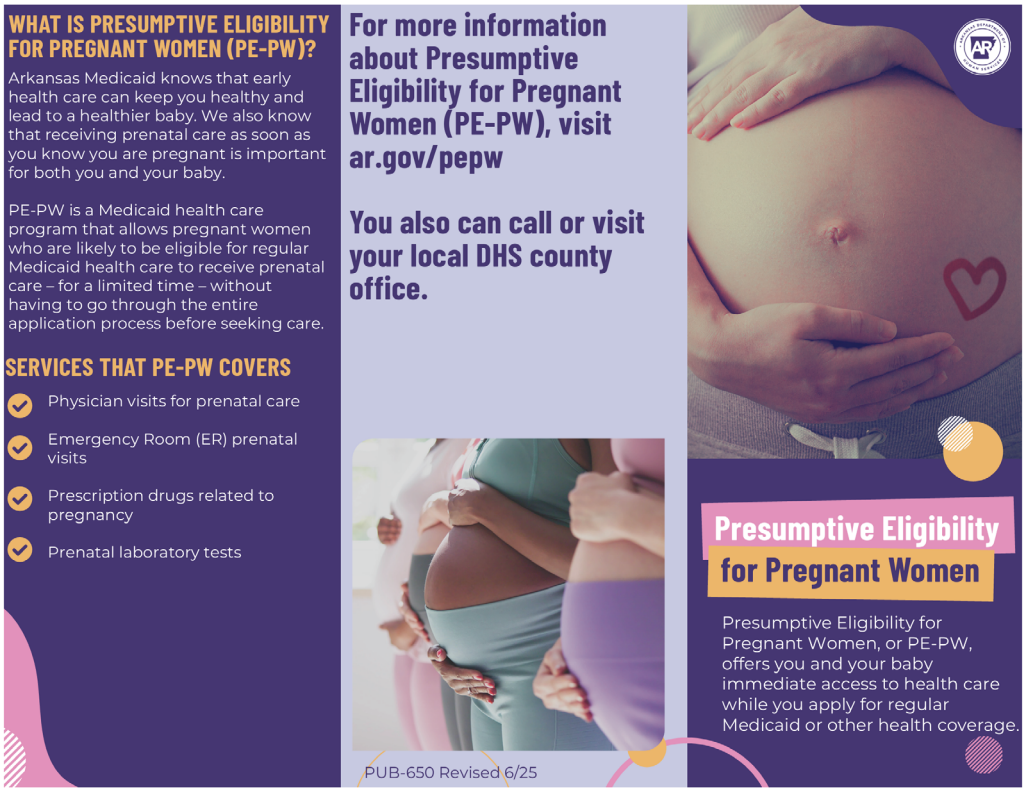
The goal of Presumptive Eligibility – Pregnant Women (PE-PW) is to offer immediate health care coverage to pregnant women likely to be eligible for Medicaid before there has been a full eligibility determination. Medicaid will provide a temporary aid category for PE-PW, with coverage restricted to prenatal services and services for conditions that may complicate the pregnancy, in an outpatient setting only.

DHS has revised the Medical Services Policy (MSP) Manual by creating Section B-280 that describes the PE-PW program, eligibility determination and length of coverage, and the process for applying for ongoing coverage. Updates will be made to Medicaid Provider Manual Section I (124.140), and the language will be mirrored in Section II of the Certified Nurse Midwife manual (215.260), Nurse Practitioner manual (214.600), and Physician manual (247.100).

II. Billing Guidelines for PE-PW Members

- Pregnancy must be indicated as the primary or secondary header diagnosis (institutional claim form), or the primary or secondary detail diagnosis (professional and dental claim forms). Note: Transportation claims (provider type 15) do not require a pregnancy diagnosis.
- Inpatient services are not included in coverage.
- Prior authorization requirements are waived under PE-PW.
- Primary Care Physician referral is not required.
- Copay is not applicable for PE-PW members.
- PE-PW members will be eligible for Non-Emergency Transport (NET) services.

For further details refer to Section II of the appropriate manuals noted above.



Obstetrics (OB) Services Billing Changes (Global/Itemized) and Postpartum Visits

Effective July 1, 2025, Arkansas Department of Human Services will no longer cover global OB codes unless the beneficiary has a Third-Party Liability (TPL) insurance and/or Medicare.

A recorded webinar about the changes to AR Medicaid billing for OB services can be reviewed at https://medicaid.afmc.org/provider-relations-policy-education/webinars.

Official Notice

TO: Health Care Providers – Ambulatory Surgical Center, Certified Nurse Midwife, Arkansas Department of Health, Federally Qualified Health Center (FQHC), Hospital, Physician, Indian Health Services, Nurse Practitioner, and Rural Health Clinic (RHC)

DATE: June 16, 2025, Revised June 26, 2025

SUBJECT: REVISED – Obstetrics (OB) Services Billing Changes (Global/Itemized) and Postpartum Visits

I. General Information

Effective July 1, 2025, Arkansas Department of Human Services will no longer cover global OB codes unless the beneficiary has Third-party Liability (TPL) insurance and/or Medicare. Please see the list of changes below.

II. OB Procedure Codes

As of July 1, 2025, the following OB procedure codes should be billed. These will be paid at the rate provided in the table below. Please reference the appropriate Procedure Code Tables for coverage guidelines.

Proc Code	Description	Mod	Provider Contract	Rate
59409	VAGINAL DELIVERY	80, 81 or 82	ASTSG	$222.16
			CNMW	$888.62
			MEDSV	$1,110.78
			OUTPA	$363.00
59425	PREDELIVERY CARE, 4 TO 6 VISITS		CNMW	$38.90
			MEDSV	$48.62
			NURSP	$38.90
59425	PREDELIVERY CARE, VISITS 1-3	UA	CNMW	$38.90
		UA	MEDSV	$48.62
		UA	NURSP	$38.90

59426	PREDELIVERY CARE, 7 OR MORE VISITS		CNMW	$38.90
			MEDSV	$48.62
			NURSP	$38.90
59514	CESAREAN DELIVERY ONLY	80, 81 or 82	ASTSG	$243.07
			MEDSV	$1,215.36
59612	VBAC DELIVERY ONLY	80, 81 or 82	ASTSG	$334.53
			CNMW	$1,338.14
			MEDSV	$1,672.66
			OUTPA	$363.00
59620	ATTEMPTED VBAC DELIVERY ONLY	80, 81 or 82	ASTSG	$385.07
			MEDSV	$1,925.35
			OUTPA	$363.00

NOTE: Rates are subject to change.

The following bundled OB procedure codes have been termed (except as described below) as of 6/30/2025.

Proc Code	Description
59400	VAGINAL DELIVERY WITH CARE BEFORE AND AFTER DELIVERY
59410	VAGINAL DELIVERY WITH POST DELIVERY CARE
59510	CESAREAN DELIVERY WITH CARE BEFORE AND AFTER DELIVERY
59515	CESAREAN DELIVERY WITH CARE AFTER DELIVERY
59610	VAGINAL DELIVERY AND CARE BEFORE AND AFTER DELIVERY AFTER PREVIOUS CESAREAN DELIVERY
59614	VAGINAL DELIVERY AND CARE AFTER DELIVERY AFTER PRIOR CESAREAN DELIVERY
59618	CESAREAN DELIVERY AND CARE BEFORE AND AFTER DELIVERY FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY
59622	CESAREAN DELIVERY WITH CARE AFTER DELIVERY FOLLOWING VAGINAL DELIVERY ATTEMPT AFTER PREVIOUS CESAREAN DELIVERY

NOTE: Bundled OB codes will be covered only for beneficiaries who have TPL insurance and/or Medicare. There will be no billing changes for these beneficiaries.

III. Postpartum Procedure Codes

As of July 1, 2025, the following postpartum procedure codes should be billed. **Postpartum visits should be billed with modifier TH (OB TX/SRVCS PRENATL/POSTPART) using the E&M codes identified below.**

- FQHCs and RHCs should bill the below E&M codes with the TH modifier.
- When the below E&M codes are billed with the TH modifier, it will bypass the 16-visit per SFY limit.

Proc Code	Mod	Description	Provider Contract	Gender	Rate*
99203	TH	OFFICE O/P NEW LOW 30 MIN – POSTPARTUM VISIT	CNMW	F	$95.47
			MEDSV	F	$119.32
			NURSP	F	$95.47
99204	TH	OFFICE O/P NEW MOD 45 MIN – POSTPARTUM VISIT	CNMW	F	$129.44
			MEDSV	F	$161.79
			NURSP	F	$129.44
99205	TH	OFFICE O/P NEW HI 60 MIN – POSTPARTUM VISIT	CNMW	F	$202.25
			MEDSV	F	$252.81
			NURSP	F	$202.25
99212	TH	OFFICE O/P EST SF 10 MIN – POSTPARTUM VISIT	CNMW	F	$40.44
			MEDSV	F	$50.58
			NURSP	F	$40.44
99213	TH	OFFICE O/P EST LOW 20 MIN – POSTPARTUM VISIT	CNMW	F	$53.38
			MEDSV	F	$66.74
			NURSP	F	$53.38
99214	TH	OFFICE O/P EST MOD 30 MIN – POSTPARTUM VISIT	CNMW	F	$103.04
			MEDSV	F	$128.79
			NURSP	F	$103.04
99215	TH	OFFICE O/P EST HI 40 MIN – POSTPARTUM VISIT	CNMW	F	$155.91
			MEDSV	F	$194.89
			NURSP	F	$155.91

NOTE: Rates are subject to change. ■

Important PASRR Updates for Providers
AFMC completing Level II Evaluations – Effective July 1, 2025

On July 1, 2025, the Arkansas Department of Human Services (DHS) transitioned to a new vendor, the Arkansas Foundation for Medical Care (AFMC), for conducting all Level II PASRR assessments. This change is part of DHS's continued efforts to ensure efficient and high-quality placement decisions for individuals entering Medicaid-certified nursing facilities.

What Is PASRR?
Pre-Admission Screening and Resident Review (PASRR) is a federally required process that ensures individuals referred for nursing facility (NF) admission are screened for Serious Mental Illness (SMI) or Intellectual/Developmental Disabilities (ID/DD).
The process includes:

- Level I Screening (Form DMS-787): Conducted before admission to identify SMI or ID/DD
- Level II Assessment: Completed if the Level I is positive, to ensure appropriate placement and identify needed services

A diagnosis of SMI or ID/DD does not prevent NF placement but does require this additional review.

What This Means for Providers
You may be asked to:

- **Provide medical documentation** to support the assessment process
- **Clarify clinical history** during the assessment process
- **Receive notification** of PASRR findings that impact care planning

Your participation helps ensure patients are placed in the most appropriate and supportive care setting.

Quick Steps (Effective June 26, 2025):

- Facilities complete Level I screening prior to NF admission
- Positive Level I + medical records sent to: MedNeeds.PASRR@dhs.arkansas.gov
- AFMC contacts the facility to schedule Level II assessment
- DHS reviews the assessment and issues a final decision
- PASRR results sent to client, facility, and guardian/representative

Have Questions?
We're here to support you throughout this transition.
Visit our website: Arkansas Pre-Admission Screening and Resident Review (PASRR)

Provider Search Features for Enhanced Accessibility Added to the Health Care Portals

New capabilities have been added to the Health Care portals to enhance search capabilities. Providers and beneficiaries can now more quickly identify providers who offer accommodations for special needs. These capabilities include:

- American Sign Language (ASL) as a searchable language option
- Facility and telehealth accommodations available as filterable criteria

All providers should review their accommodation information and update it. Providers seeking to complete revalidation, enrollment, or re-enrollment with Arkansas Medicaid will be required to review and provide accommodation information to submit their applications.

Further search enhancements and self-service tools to update provider information are coming soon. ■

New Electronic Submission Requirements for Provider Enrollment Applications and Updates

Effective July 15, 2025, initial provider enrollment applications (except Long Term Care Facilities) must be submitted electronically through the provider portal.

Online submission is the fastest and most effective way to enroll as an Arkansas Medicaid Provider because

- enrollment time decreases — from weeks to days.
- issues related to the quality of attachments and illegible applications are decreased or eliminated.
- real-time status updates on applications are available.
- applications are returned to providers less frequently for clarification or additional information and no associated mailing delays occur.
- application delays often result in failure to meet revalidation requirements causing a provider to temporarily lose the ability to bill for services.
- a higher percentage of electronic application submissions are successful.

For the rare occasions when a provider is unable to enroll using the portal, the state will review the situation and may approve submission of a paper application on a case-by-case basis. State review and approval will only occur if the provider has exhausted all options to enroll using the portal.

In addition to the new electronic enrollment requirement, paper requests received by Provider Enrollment for tasks and updates that can be completed using the self-service option will be returned to the provider.

A new job aid will soon be added to the Provider Training Information webpage that will outline self-service options and how to use them.

As noted earlier, Long Term Care Facilities are not required to submit enrollment applications electronically through the portal. Currently, these applications for enrollment must be submitted by paper application. General information from the Office of Long Term Care (OLTC) along with contact information for assistance with enrollment questions can be found on the OLTC webpage. ■

How to Submit Primary Care Provider (PCP) Disenrollment Documents

Providers should upload PCP disenrollment documents through the Arkansas Medicaid Healthcare Portal. After logging in, navigate to **Provider Functions** > **Submit an Update Request** and select "**PCP Agreement Request**" as the document type. Be sure to upload the appropriate file and click **Add and Submit** to complete the process. For visual instructions, refer to the MMIS Job Aid – Uploading Documents. ■

AR Medicaid Provider Portal – 24 Hour Phone Number Update

To update a Provider's 24-hour number that appears on the eligibility page, the Provider must compose and sign a letter addressed to Gainwell Technologies, Provider Enrollment and request that his/her 24-hour phone number be updated in the Medicaid Provider Portal. This letter should provide the provider's AR Medicaid number and be uploaded in the Provider Portal.

Instructions for uploading documents to the Provider Portal: Health Care Portal Job Aid: How to Upload Documents. ■

Applied Behavior Analysis (ABA) Therapy Provider Information

Providers can utilize the AR Medicaid provider manual for general information about ABA therapy, provider requirements, eligibility, program services, prior authorization, and reimbursement.

AR Medicaid Provider Manual for ABA Therapy

An ABA Therapy Provider Memorandum was released on 2/1/2025. The link to the memorandum and ABA therapy process is provided below.

ABA Therapy Provider Memorandum

Process for Qualifying for ABA Therapy Services

Billing Resources: Procedure Code Table and Fee Schedule for ABA Therapy

AR Medicaid provides a fee schedule and procedure code table for ABA therapy services. Although the fee schedule and procedure code table does not guarantee payment, coverage limitations, and reimbursement amount, they are a great resource.

Procedure Code Tables

Applied Behavior Analysis (ABA) Therapy Fee Schedule

Prior Authorization is required for an ABA therapy provider to be reimbursed for ABA therapy services. Acentra Health is the AR Medicaid vendor that processes prior authorization requests. Please review the ABA Provider Manual and Acentra Health's documentation to learn more about the program and the process for submitting a prior authorization for ABA therapy services - Applied Behavioral Analysis (ABA) - Arkansas Department of Human Services.

Referral to Evaluation (Section 212.300 AR Medicaid ABA Therapy Manual)

Applied behavior analysis (ABA) therapy services require an initial evaluation referral signed and dated by:

1. The beneficiary's Arkansas Medicaid assigned primary care provider (PCP);
2. A substitute physician in accordance with section 171.600 of this Arkansas Medicaid manual; or
3. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.

An initial evaluation referral is required to be completed on a form DMS-641 ER "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Evaluation Referral." View or print the form DMS-641 ER.

A DMS-641 ER evaluation referral is only required to perform the initial comprehensive evaluation related to ABA therapy services.

No evaluation referral is required for an ABA therapy provider to perform a comprehensive reevaluation necessary to demonstrate a beneficiary's continued eligibility for ABA therapy services (see section 212.500(B) of the AR Medicaid ABA therapy manual).

When a beneficiary has an active treatment prescription for ABA therapy services pursuant to a DMS-641 TP and switches to a new ABA therapy provider, the new provider is not required to obtain or maintain in the beneficiary's service record a DMS-641 ER since any evaluation performed by the new provider would not be the beneficiary's initial comprehensive evaluation for ABA therapy services.

If a beneficiary becomes ineligible for ABA therapy services at any time, then another, new DMS-641 ER evaluation referral and initial comprehensive evaluation is required prior to restarting ABA therapy services.

Treatment Prescription (Section 212.400 AR Medicaid ABA Therapy Manual)

Applied behavior analysis (ABA) therapy services require a treatment prescription signed and dated in accordance with the following:

1. A beneficiary's initial treatment prescription must be signed and dated by the beneficiary's Arkansas Medicaid assigned primary care provider (PCP).
2. A beneficiary's renewal treatment prescription must be signed and dated by:
    a. The beneficiary's Arkansas Medicaid assigned PCP;
    b. A substitute physician in accordance with section 171.600 of this Arkansas Medicaid manual; or
    c. An affiliated physician or PCP operating under the same Arkansas Medicaid group provider as the Arkansas Medicaid assigned PCP.

Unless a shorter time is specified on the treatment prescription, a treatment prescription for ABA therapy services is valid for:

1. Up to six (6) months for a beneficiary from eighteen (18) months to eight (8) years of age; and
2. Up to twelve (12) months for a beneficiary from eight (8) to twenty-one (21) years of age.
    a. Age is determined based on the beneficiary's age as of the date of the treatment prescription.

A treatment prescription for ABA therapy services must be on a form DMS-641 TP "Applied Behavior Analysis Therapy Services for Medicaid Eligible Beneficiaries from 18 months to 21 Years of Age Treatment Prescription." View or print the form DMS-641 TP.

Beneficiaries who are already receiving ABA therapy services pursuant to an active treatment prescription (on a DMS-693 form) as of January 1, 2025, are not required to obtain a new treatment prescription on a form DMS-641 TP until their existing treatment prescription expires.

A new DMS-641 TP treatment prescription is not required when a beneficiary changes PCPs. An existing treatment prescription would remain valid through its date of expiration if it was valid at the time originally signed. ■

Arkansas Medicaid Electronic Prior Authorization via CoverMyMeds®

Beginning 8/1/2025, the Arkansas Medicaid Prescription Drug Program will add new functionality to begin accepting electronic prior authorization (ePA) requests via CoverMyMeds®, in addition to fax requests.

CoverMyMeds is a tool designed to simplify the prior authorization process by prompting prescribers to answer required clinical questions and can offer real-time approvals if clinical criteria are met. Prescribers will be able to electronically submit prior authorization requests, upload supporting documents, and track request status in real time.

Additionally, pharmacy providers who utilize CoverMyMeds will have the opportunity to initiate medication ePA requests on behalf of the member for completion by the prescriber. CoverMyMeds will direct the case to the prescriber's queue and prompt them to complete and submit the ePA to Arkansas Medicaid.

What Pharmacy Providers and Prescribers Need to Do

- Read the Quick Guide to CoverMyMeds Prior Authorization Requests to learn more about CoverMyMeds.
- Visit the CoverMyMeds Log In page to create an account, complete your profile, and become familiar with the application.

Note: Please ensure that all information in your profile is accurate.

Resources

- CoverMyMeds Website
- Quick Guide to CoverMyMeds Prior Authorization Requests
- Arkansas Medicaid Pharmacy Portal

Contact Information

For questions related to CoverMyMeds technical support, contact the CoverMyMeds Call Center by phone at 1-866-452-5017 or by live chat at www.covermymeds.com from 8:00 AM to 8:00 PM ET, Monday through Friday, excluding holidays. ■

Two Ways to Submit a Prior Authorization to Arkansas Medicaid Prescription Drug Program

ePA Submission via CoverMyMeds (beginning 8/1/2025)
www.covermymeds.com
The CoverMyMeds electronic prior authorization (ePA) request submission portal allows pharmacy providers to initiate ePA requests and prescribers to submit ePA requests, with covered alternatives and approvals given in real time. Providers can create an account or log into the CoverMyMeds portal from the CoverMyMeds homepage. For more information, see Arkansas Medicaid Prescription Drug Program ePA FAQs on the Arkansas Medicaid Pharmacy Portal.
Fax Submission
1-800-424-7976
Prescribers or their authorized agent can submit a prior authorization (PA) request via fax by utilizing the authorized Arkansas Medicaid PA forms available on the Arkansas Medicaid Pharmacy Portal under the Resources tab. Fax submissions are responded to within 1 business day.

Contact Information

- The CoverMyMeds Support Center is available by phone at 1-866-452-5017 from 8:00 AM to 8:00 PM ET, Monday through Friday, excluding holidays or via CoverMyMeds live chat.
- The Prime Therapeutics Pharmacy Call Center is available by phone at 1-800-424-7895 from 8:00 AM to 5:00 PM CST, Monday through Friday, excluding holidays. ■

Arkansas Medicaid Management Information System (MMIS)

The Arkansas Department of Human Services Medicaid Management Information System (MMIS) streamlines claims processing and provides a more efficient reimbursement method for providers. Arkansas Medicaid providers can submit claims and other documents electronically.

AFMC's MMIS Billing outreach specialists are available to help providers with questions about billing requirements and claim processing. The MMIS billing team are adept researchers, problem solvers and decision makers.

Contact an MMIS Outreach Specialist

Download the Billing Outreach Specialist Map to identify your MMIS Outreach Specialist for your billing questions. They are available to answer your questions by email or phone. Please remember to include your provider number with all correspondence.

Have you registered?

You must register to use the MMIS provider portal.

What can Medicaid providers do with the provider portal?

- Submit claims
- Check remittance advice
- Submit prior authorization
- Upload documents
- Complete LTC census
- Check on the status of their claims
- Inquire on a patient's eligibility
- Upload files containing 837 transactions
- Search for another provider

You can find additional resources on the portal:

- Health plan information
- Resources

MMIS Webinars and Workshop Recordings

- New! Annual Billing Conference 2025 - Presentation downloads are available at the top of the page under "MMIS Resources" in the "Training Materials" folder.
- New! Children's Advocacy Center (CAC) Billing 2025
- Dental Claims
- Electronic Visit Verification (EVV)
- First Connections Healthcare Portal Training
- Institutional Claims
- Long-Term Care Workshop
- Medicaid 101
- MyARMedicaid Application
- Portal Registration
- New! New Provider Workshop 2025
- Nursing Home Claims and Census Forms
- Procedure Code Linking Tables Training
- Professional Claims

Additional billing resources can be found at https://medicaid.afmc.org/mmis-resources. ■

Congenital Syphilis Screening and Prevention

Arkansas is facing a substantial increase in congenital syphilis cases. According to the Arkansas Department of Health, from 2017 to 2023, reported cases have surged nearly five times, from 13 to 64. Tragically, during this period, 23 infants died due to congenital syphilis. Additionally, the state ranks 4th nationally in primary and secondary syphilis rates, with 896 cases reported in 2023. Alarmingly, approximately 50% of congenital syphilis cases are linked to inadequate or delayed maternal testing and treatment.

AFMC's Medicaid Quality Improvement (MQI) team, contracted by Arkansas Medicaid, is implementing a quality improvement project providing guidance to all Arkansas providers who serve pregnant women to meet American College of Obstetricians and Gynecologists (ACOG) recommendations for syphilis screening. In 2024, ACOG issued a new Practice Advisory that recommends universal syphilis screening for all pregnant women at the **first prenatal care visit, during the third trimester, and again when a pregnant woman arrives to give birth.**

ACOG strongly encourages providers to implement standardized processes to ensure that all pregnant women are counseled and offered syphilis screening at the three recommended intervals. At times, it may be necessary to screen pregnant women at healthcare encounters outside of routine prenatal and delivery care, including visits to the emergency department and labor & delivery triage. **Per Arkansas Medicaid policy, claims with specific primary diagnoses, including pregnancy, are exempt from laboratory service benefit limits.**

Our Congenital Syphilis Screening and Prevention Project supports healthcare providers in:

- Early Screening & Detection of Syphilis: Screen all pregnant women for syphilis at the first prenatal visit, during the third trimester, and at delivery.
- Prompt Treatment of Pregnant Women and their Partner(s): Initiate immediate treatment for positive cases to prevent transmission to the baby and prevent the pregnant woman from becoming re-infected.
- Newborn Evaluation and Treatment: Assess and treat infants at risk for congenital syphilis promptly to prevent severe health complications.

Please contact mqi@afmc.org for additional information and questions. ■

Save the Date - 2026 PCMH Open Enrollment

Open enrollment for the 2026 AR Medicaid Performance period is scheduled for **October 6, 2025 – November 17, 2025.**

All four of these requirements must be met to be eligible for enrollment as a Patient Centered Medical Home (PCMH).

- The Provider entity must be one of the following:
  - An individual Primary Care Physician (PCP) (Medicaid Provider Types 01 or 03)
  - A physician group of Primary Care Providers who are affiliated with a common group Medicaid identification number (Provider Types 02 or 04)
  - A Rural Health Clinic (Medicaid Provider Type 29) as defined by the Rural Health Clinic Provider Manual, Section 201.000
  - An Area Health Education Center (AHEC) (Medicaid Provider Type 69)
- The practice must include PCPs enrolled in the ConnectCare Primary Care Case Management program
- The practice may not participate in the PCCM Shared Savings Program established under AR Act 1453 of 2013
- The practice must have at least 125 attributed beneficiaries at the time of enrollment ■

Important Messages for AR Medicaid Providers

New Provider Manual Updates

Arkansas Medicaid released FQHC-1-25 provider manual update. View or print the FQHC-1-25 transmittal letter. View or print changes to the Federally Qualified Health Center (FQHC) provider manual.

Arkansas Medicaid released RURLHLTH-1-25 provider manual update. View or print the RURLHLTH-1-25 transmittal letter. View or print changes to the Rural Health Clinic (RHC) provider manual.

Arkansas Medicaid released CNM-1-25 provider manual update. View or print the CNM-1-

25 transmittal letter. View or print changes to the Certified Nurse-Midwife provider manual.

Arkansas Medicaid released CNM-2-25 provider manual update. View or print the CNM-2-25 transmittal letter. View or print changes to the Certified Nurse-Midwife provider manual.

Arkansas Medicaid released NURSEPRA-1-25 provider manual update. View or print the NURSEPRA-1-25 transmittal letter. View or print changes to the Nurse Practitioner provider manual.

Arkansas Medicaid released NURSEPRA-2-25 provider manual update. View or print the NURSEPRA-2-25 transmittal letter. View or print changes to the Nurse Practitioner provider manual.

Arkansas Medicaid released PHYSICN-1-25 provider manual update. View or print the PHYSICN-1-25 transmittal letter. View or print changes to the Physician provider manual.

Arkansas Medicaid released PHYSICN-2-25 provider manual update. View or print the PHYSICN-2-25 transmittal letter. View or print changes to the Physician provider manual.

Arkansas Medicaid released SecI-1-25 all provider manuals update. View or print the SecI-1-25 transmittal letter. View or print changes to Section I of all provider manuals. ■

What's New for Arkansas Medicaid Providers

Official notices posted from April 1, 2025 – June 30, 2025. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers. In addition to Medicaid provider manuals, official notices should be referenced for Medicaid program policy.

Title	Posted Date	Category
REVISED New Coverage - Presumptive Eligibility - Pregnant Women (PE-PW)	07/02/2025	Billing Instruction
New Formula Procedure Codes and Formula Rate Changes - Effective 7/15/2025	07/01/2025	Procedure Codes
Prescribing Information for Durable Medical Equipment and Updates to Orthotic Procedure Codes L3204, L3206, and L3207	06/30/2025	Procedure Codes
REVISED - Obstetrics (OB) Services Billing Changes (Global/Itemized) and Postpartum Visits	06/26/2025	Procedure C odes
New Electronic Submission Requirements for Provider Enrollment Applications and Updates	06/06/2025	Provider Enrollment
Allow beneficiary to continue previously authorized services for thirty-five days after adverse action is received on subsequent Prior Authorization (PA) request	06/05/2025	Prior Authorizations
Hospice Provider Manual Updates	05/30/2025	Billing Instruction
NDC Billing Changes-REVISED	05/10/2025	Billing Instruction
Allow Initial Prior Authorization (PA) Requests for ten (10) days for Acute Care Rehabilitation Hospital Stays	04/30/2025	Prior Authorizations
2025 Quarter 2 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion	04/30/2025	Procedure Codes
New Edit for 340B Medical Billing	04/29/2025	Billing Instruction
2025 ICD-10-PCS Revisions - Effective 4/1/2025	04/10/2025	Procedure Codes

TO: Health Care Providers – Rehabilitation Hospital Provider Type 26, Specialty R1

DATE: April 30, 2025

SUBJECT: Allow Initial Prior Authorization (PA) Requests for ten (10) days for Acute Care Rehabilitation Hospital Stays

I. General Information

Effective May 1, 2025, Arkansas Department of Human Services will make changes to allow Rehabilitation Hospital providers (PT 26/R1) to submit initial PA requests through the Provider Portal for ten (10) days rather than seven (7) days.

II. PA Process

1. Providers may submit new Prior Authorization (PA) requests for the first ten (10) days of the Rehabilitation Hospital stay rather than seven (7).
2. The process to submit PA requests has not changed.
3. Providers will continue to submit PA request via the Provider Portal as they do today.
4. Include documentation supporting the PA request for the initial ten (10) days. The following documentation is needed:
   - Admission History and Physical- This can be a summary of the H&P or the full document.
   - Therapy evaluations with goals and any outcomes if available as of the date of submission.
   - Daily clinical information to document the severity of illness and intensity of service for each day- This may include a summary of the daily clinical information, or a daily progress note for each date of service.
   - Therapy notes showing time of session, participation, and progress.
   - Discharge planning to document any issues that could affect discharge such as placement issues or equipment needs.
5. The submission of a PA request does not guarantee approval. Documentation submitted must support the medical necessity for the admission.
6. If additional/subsequent hospital days are needed, PA extensions can be requested through the normal process used today (PA Extensions may be requested through the Provider Portal).
7. Prior authorization of service does not guarantee eligibility for a member. Payment is still subject to verification that the member was eligible at the time services are provided.
8. All records are subject to retrospective review.

Messages for AR Medicaid Providers

Messages for Remittance Advices dated June 26, 2025 – July 3, 2025

TO: ALL PROVIDERS	RE: PROVIDER SEARCH FEATURES FOR ENHANCED ACCESSIBILITY ADDED TO THE HEALTH CARE PORTALS

New capabilities have been added to the Health Care portals to enhance search capabilities. Providers and beneficiaries can now more quickly identify providers who offer accommodations for special needs. These capabilities include:

- American Sign Language (ASL) as a searchable language option
- Facility and telehealth accommodations available as filterable criteria

All providers should review their accommodation information and update it. Providers seeking to complete revalidation, enrollment, or re-enrollment with Arkansas Medicaid will be required to review and provide accommodation information in order to submit their applications.

Further search enhancements and self-service tools to update provider information are coming soon.

TO: ALL PROVIDERS	RE: NEW ELECTRONIC SUBMISSION REQUIREMENTS FOR PROVIDER ENROLLMENT APPLICATIONS AND UPDATES

Effective July 15, 2025, initial provider enrollment applications (except Long Term Care Facilities) must be submitted electronically through the provider portal at https://portal.mmis.arkansas.gov/armedicaid/provider/Home/ProviderEnrollment/tabid/477/Default.aspx

Online submission is the fastest and most effective way to enroll as an Arkansas Medicaid Provider because

- enrollment time decreases — from weeks to days.
- issues related to the quality of attachments and illegible applications are decreased or eliminated.
- real-time status updates on applications are available.
- applications are returned to providers less frequently for clarification or additional information and no associated mailing delays occur.
- application delays often result in failure to meet revalidation requirements causing a provider to temporarily lose the ability to bill for services.
- a higher percentage of electronic application submissions are successful.

For the rare occasions when a provider is unable to enroll using the portal, the state will review the situation and may approve submission of a paper application on a case-by-case basis. State review and approval will only occur if the provider has exhausted all options to enroll using the portal.

In addition to the new electronic enrollment requirement, paper requests received by Provider Enrollment for tasks and updates that can be completed using the self-service option will be returned to the provider.

A new job aid will soon be added to the Provider Training Information webpage (ar.gov/ProviderTrainingInfo) that will outline self-service options and how to use them.

As noted earlier, Long Term Care Facilities are not required to submit enrollment applications electronically through the portal. Currently, these applications for enrollment must be submitted by paper application. General information from the Office of Long Term Care (OLTC) along with contact information for assistance with enrollment questions can be found on the OLTC webpage at ar.gov/oltc.

TO: NURSE PRACTITIONERS **RE: PROCEDURE 99417 ADDED TO AUDIT 6890**

The Arkansas Department of Human Services has updated Audit 6890 [16 PROVIDER VISITS PER SFY] to include procedure 99417 [PROLNG OP E/M EACH 15 MIN] for Nurse Practitioners. This limitation audit ensures that members are allowed 16 visits per State Fiscal Year for members age 21-999.

TO: AMBULATORY SURGICAL CENTER (ASC), ARKANSAS DEPARTMENT OF HEALTH (ADH), CERTIFIED NURSE-MIDWIFE (CNM), FEDERALLY QUALIFIED HEALTH CENTER (FQHC), NURSE PRACTITIONER, HOSPITAL, PHYSICIAN, AND RURAL HEALTH CLINIC **RE: OBSTETRICS (OB) SERVICES BILLING CHANGES (GLOBAL/ITEMIZED) AND POSTPARTUM VISITS**

Effective July 1, 2025, Arkansas Department of Human Services:

1. Will no longer cover global OB codes unless the beneficiary has Third-party Liability (TPL) insurance and/or Medicare.
2. Applicable E&M procedure codes with TH (OB TX/SRVCS PRENATL/POSTPART) modifier to be billed for postpartum visits.

Please reference ON-019-25 for a complete list of codes that should be billed.

https://humanservices.arkansas.gov/wp-content/uploads/ON-019-25.docx

TO: ALL PROVIDERS **RE: VACCINE/IMMUNIZATION BILLING RULES**

There is a phased effort over the next few months to review and update the vaccine and immunization procedure codes to ensure they are set up appropriately for each applicable provider contract. The corresponding procedure code tables will be updated as the updates are completed.

TO: FAMILY PLANNING CLINIC, HOSPITAL, INDEPENDENT LABORATORY, NURSE PRACTITIONER, PHYSICIAN, AND REHABILITATION CENTER PROVIDERS **RE: CLIA WAIVED CODES WITH MOD QW**

The following procedure codes have been updated to be CLIA Waived:

87521 QW - effective 10/01/2024

81515 QW - effective 01/01/2025

87563 QW - effective 01/16/2025

87491 QW - effective 01/16/2025

87591 QW - effecitve 01/16/2025

Claims analysis will be performed to identify any claims that may have been impacted due to a retroactive update.

TO: ALL PROVIDERS **RE: NEW COVERAGE - PRESUMPTIVE ELIGIBILITY – PREGNANT WOMEN (PE-PW)**

On July 1, 2025, and effective for dates of service on or after June 9, 2025, the Department of Humans Services (DHS) is adding presumptive eligibility for pregnant women under Medicaid, pursuant to Acts 124 and 140 of 2025. Presumptive Eligibility – Pregnant Women (PE-PW) is to offer immediate health care coverage to pregnant women likely to be eligible for Medicaid before there has been a full eligibility determination. Medicaid will provide a temporary aid category for PE-PW, with coverage restricted to prenatal services and services for conditions that may complicate the pregnancy, in an outpatient setting only.

Please reference ON-020-25 for more details and billing guidelines for PE-PW Members.

TO: AREA HEALTH EDUCATION CENTER (AHEC) AND PHYSICIAN PROVIDERS	RE: PLACE OF SERVICE UPDATES FOR PROCEDURE CODE 50693

The Arkansas Department of Human Services has updated coverage in the MEDSV and ASTSG contracts to allow procedure 50693 [PLMT URETERAL STENT PRQ] to be performed in an ASC Place of Service (24).

Claims analysis will be performed going back one year.

Messages for Remittance Advices dated June 12, 2025 – June 19, 2025

TO: HOSPICE PROVIDERS	RE: HOSPICE PROVIDER MANUAL UPDATES

Effective June 1, 2025, Arkansas Department of Human Services will update the following sections of the Hospice Provider Manual.

- Section 220.200 - Added sub-section K instructing providers to complete the new form, DMS-9939, when a beneficiary is being admitted or discharged, and providing a hyperlink to the new form.
- Section 250.230 - Updated field 04 to include reference to streamline hospice provider coding for claims.

Messages for Remittance Advices dated June 5, 2025 – June 12, 2025

TO: AREA HEALTH EDUCATION CENTER (AHEC) AND PHYSICIAN PROVIDERS	RE: PLACE OF SERVICE UPDATES FOR PROCEDURE CODE 50435

The Arkansas Department of Human Services has updated coverage in the MEDSV and ASTSG contracts to allow procedure 50435 [EXCHANGE NEPHROSTOMY CATH] to be performed in an ASC Place of Service (24).

Claims analysis will be performed going back one year.

TO: CERTIFIED NURSE-MIDWIFE PROVIDERS	RE: FETAL ULTRASOUND PROCEDURE CODES COVERED FOR CERTIFIED NURSE MIDWIVES

Arkansas Department of Human Services has updated the system to include covering the below Fetal Ultrasound procedure codes when rendered by a Certified Nurse Midwife effective June 1, 2025.
76801 - OB US < 14 WKS SINGLE FETUS
76802 - OB US < 14 WKS ADDL FETUS
76805 - OB US >= 14 WKS SNGL FETUS
76810 - OB US >= 14 WKS ADDL FETUS
76811 - OB US DETAILED SNGL FETUS
76812 - OB US DETAILED ADDL FETUS
76813 - OB US NUCHAL MEAS 1 GEST
76814 - OB US NUCHAL MEAS ADD-ON
76815 - OB US LIMITED FETUS(S)
76817 - TRANSVAGINAL US OBSTETRIC

TO: REHABILITATION HOSPITAL PROVIDER TYPE 26, SPECIALTY R1

RE: ACUTE CARE REHABILITATION HOSPITAL PRIOR AUTHORIZATIONS (PAS)

Effective May 1, 2025, Arkansas Department of Human Services will make changes to allow Rehabilitation Hospital providers (PT26/R1) to submit initial PA requests through the Provider Portal for ten (10) days rather than seven (7) days.

PA Process

1. Providers may submit new Prior Authorization (PA) requests for the first ten (10) days of the Rehabilitation Hospital stay rather than seven (7).
2. The process to submit PA requests has not changed.
3. Providers will continue to submit PA request via the Provider Portal as they do today.
4. Include documentation supporting the PA request for the initial ten (10) days. The following documentation is needed:
   - Admission History and Physical- This can be a summary of the H&P or the full document.
   - Therapy evaluations with goals and any outcomes if available as of the date of submission.
   - Daily clinical information to document the severity of illness and intensity of service for each day- This may include a summary of the daily clinical information, or a daily progress note for each date of service.
   - Therapy notes showing time of session, participation, and progress.
   - Discharge planning to document any issues that could affect discharge such as placement issues or equipment needs.
5. The submission of a PA request does not guarantee approval. Documentation submitted must support the medical necessity for the admission.
6. If additional/subsequent hospital days are needed, PA extensions can be requested through the normal process used today (PA Extensions may be requested through the Provider Portal).
7. Prior authorization of service does not guarantee eligibility for a member. Payment is still subject to verification that the member was eligible at the time services are provided.
8. All records are subject to retrospective review.

https://humanservices.arkansas.gov/wp-content/uploads/ON-013-25.docx

TO: NURSE PRACTITIONER AND PHYSICIAN PROVIDERS

RE: EPSDT SERVICES - EXTENSION OF BENEFIT REQUESTS

Providers are to request the extension of benefits for procedure code 96110- Developmental Screening Services for Process Type 126 (Professional Services) through AFMC via the Provider Portal. https://portal.mmis.arkansas.gov
To submit the request for the extension of benefit, users will log onto the Provider Portal and submit a Prior Authorization request for the extension of benefit. Please include the Remittance Advice (RA) and clinical documentation to support the additional screening.
Please note:

- Requests for extensions must be submitted to DHS or its designated vendor.
- Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
- Benefit extension requests must be received within ninety (90) calendar days of the date of the benefit-exhausted denial.
- A copy of the Remittance Advice (RA) reflecting the claim's denial for exhausted benefits must be submitted with the request.
- A copy of the claim is not required for the benefit extension request.
- An extension of benefit request must match the denied claim.

Contact information for AFMC is located at the below link. https://humanservices.arkansas.gov/wp-content/uploads/AFMC.doc
For additional information regarding how to submit the extension of benefit, please go to https://share.vidyard.com/watch/2N8NnemBmoBwrXtaRwvbJc

TO: AMBULATORY SURGICAL CENTER (ASC), AREA HEALTH EDUCATION CENTER (AHEC), ARKANSAS DEPARTMENT OF HEALTH (ADH), CERTIFIED NURSE-MIDWIFE (CNM), HOSPITAL, NURSE PRACTITIONER, PHARMACY, AND PHYSICIAN PROVIDERS	RE: AGE UPDATE FOR PROCEDURE CODE 90739 HEPB VACC 2/4 DOSE ADULT IM

The Arkansas Department of Human Services has updated the age restriction for procedure code 90739 [HEPB VACC 2/4 DOSE ADULT IM] from 19-45 to 19-999. This update is retroactive to 10/1/2023.

Claims analysis will be performed to identify and reprocess any claims that may have denied before the age was updated.

Thank you for your participation in the Arkansas Medicaid Program. If you have questions regarding these messages, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211. Remittance Advices can be found using Search Payment History on the Arkansas Medicaid Provider Portal at https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx**.**

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

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**
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Sonja Savage..... **479- 653-8439**
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Supervisor, Outreach Logistics

Tonyia Long **501-212-8686**
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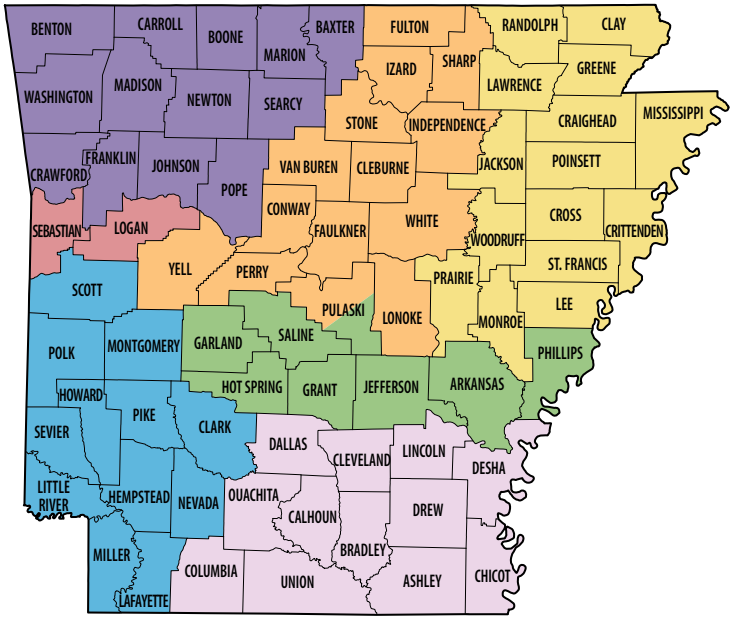

07/28/2025

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

ELECTRONIC DATA INTERCHANGE (EDI), PROVIDER ASSISTANCE CENTER (PAC), AND PROVIDER ENROLLMENT

In-state toll free **800-457-4454**
Local and out-of-state **501-376-2211**
Monday through Friday 8 a.m. until 5:00 p.m.

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**

MEDICAID PHARMACY VENDOR: PRIME THERAPEUTICS MANAGEMENT, LLC

• PDL Call Center **800-424-7895**
ar.primetherapeutics.com

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

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ARKANSAS PROVIDER MEDICAID UPDATE

Q1 SFY 2026
(July–September 2025)

- Applied Behavior Analysis (ABA) Therapy
- Congenital Syphilis Screening and Prevention
- Electronic Prior Authorization CoverMyMeds®
- OB Billing Changes
- Presumptive Eligibility (PE-PW)
- Provider Enrollment Applications and Updates

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