ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PROVIDER MEDICAID UPDATE

Q1 SFY 2027
(July–September 2026)

What's New for Arkansas Medicaid Providers

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

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Healthy People. Healthy Businesses. Healthy Communities.

AR Connecting Kids to Coverage: Helping Families Stay Covered!

AFMC's AR Connecting Kids to Coverage (CKC) initiative helps eligible children, pregnant women, and families apply for and keep AR Medicaid and CHIP coverage so they can access checkups, immunizations, prescriptions, dental care, behavioral health support, and other essential services. The initiative is supported by funding from the Centers for Medicare & Medicaid Services (CMS) through the U.S. Department of Health and Human Services (HHS). What services the initiative offers:

- Free, confidential help with Medicaid and CHIP applications and renewals
- Outbound calls and text reminders before renewal deadlines to help families avoid losing coverage
- Bilingual assistance for families who speak English as a second language
- Live web chat and contact form support through the CKC website
- Follow-up after applications are submitted to help with documents, approval status, and next steps
- Referrals to Marketplace coverage when Medicaid eligibility is denied

Back-to-school outreach

As part of this initiative, AFMC offers back-to-school tools and educational outreach materials to help families get assistance with new applications and renewals. These resources reinforce that enrollment is open year-round and include a phone number for an AFMC Enrollment Specialist, a QR code linking to the CKC website, and free support materials in English, Spanish, and Marshallese. In addition to back-to-school materials, the website also offers live web chat, a contact form for questions, and general enrollment support for families who need help with applications, renewals, or next steps.

AFMC Enrollment Specialists also attend community health fairs and back-to-school events to provide on-site application and renewal assistance, making it easier for families to get children covered before classes begin.

Enrollment is open year-round. To learn more about AR Connecting Kids to Coverage, visit afmc.org/ckc or email arconnectingkids@afmc.org.

PORTIONS OF THIS MATERIAL WERE PREPARED BY THE ARKANSAS FOUNDATION FOR MEDICAL CARE INC. (AFMC) PURSUANT TO A CONTRACT WITH THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES. THE CONTENTS PRESENTED DO NOT NECESSARILY REFLECT ARKANSAS DHS POLICIES. THE ARKANSAS DEPARTMENT OF HUMAN SERVICES IS IN COMPLIANCE WITH TITLES VI AND VII OF THE CIVIL RIGHTS ACT.

Make sure your child is ready for whatever the school year brings.

Arkansas Medicaid and AR Kids First B offer free or low-cost health insurance for kids and teens up to age 19.

Coverage includes:

- Doctor and dentist visits
- Shots and immunizations
- Prescriptions
- Mental health services
- Preventive checkups
- Emergency services

Need Help Applying or Renewing? We're Here for You.

Even if:

- You were denied before
- You lost coverage
- Your income changed
- You don't have time to apply on your own

Your child may qualify now!

Enrollment is open year-round. It's always a good time to apply.

Call **800-272-1260** to speak with a local enrollment specialist.
Or scan the QR code to get help online.

All help is free and confidential.

This poster is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $3M, with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CMS/HHS, or the U.S. Government.

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Preventive Checkups. Prescriptions. Mental Health Services. Is Your Teen Covered?

Your teen may be eligible for AR Medicaid or AR Kids First B health insurance up to age 19. This program covers them for:

- Doctor and dentist visits
- Prescriptions
- Shots and immunizations
- Mental health services
- Preventive checkups
- Emergency services

Don't wait. Enrollment is open year-round, so it's always a good time to apply.

Our Team is Ready to Help

If your teen was ineligible or lost coverage, they may qualify today.

Talk to an enrollment specialist for free:

- Call **800-272-1260**
- Scan the QR code to chat online
- Fill out the online form at **afmc.org/ckc**

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Section IV Provider Enrollment Affiliation/ Disaffiliation Form

The section IV form of the Medicaid provider enrollment application is used to authorize a group practice or organization to submit Medicaid claims on behalf of individual providers who are affiliated with the group. The effective date for group affiliation must be within 12 months of the enrollment application. That is, a provider must render Medicaid services under the group ID no more than 12 months prior to their application to establish an affiliation. Services rendered more than one year prior to enrollment cannot be accepted as the effective date.

If the form is completed to disaffiliate a provider from a group practice or organization, the provider leaving the group has no obligation to sign or complete the form. Gainwell Provider Enrollment requires a section IV form be signed and dated by someone within the group practice or organization, along with their title, confirming that they agree to disassociate the provider from the group. The completed section IV form must be uploaded to the provider's individual MMIS profile for processing by Gainwell Provider Enrollment. Section IV - Group Affiliation

Autism Spectrum Disorder Diagnosis Requirements for Primary Care Providers

Jennifer Brezée, Director
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MEMORANDUM

TO: Arkansas Medicaid Enrolled Primary Care Providers
FROM: Jennifer Brezée, Director
DATE: May 27, 2026
SUBJECT: Autism Spectrum Disorder Diagnosis Requirements

The Division of Developmental Disabilities Services (DDS) has received several inquiries from primary care providers (PCP) concerning children receiving an autism spectrum disorder (ASD) diagnostic evaluation and diagnosis from another provider. The common theme of these inquiries is that the licensed physician PCP has been asked by a parent, service provider, or the other diagnosing qualified professional to act as the 2nd qualified professional that Arkansas Medicaid requires for a valid ASD diagnosis.

An ASD diagnosis must be established by two (2) "qualified professionals," operating within their clinical scope of practice, in accordance with Arkansas Code § 20-77-124, for a beneficiary to qualify for the Autism waiver or applied behavior analysis therapy. The statute lists a licensed physician as one of the types of "qualified professional." The ASD diagnosis of each qualified professional must be demonstrated in one of the following two ways:

1. The administration of one or more properly administered ASD evaluation instruments, such as the Child Autism Rating Scale (CARS) or Autism Diagnostic Observation Schedule (ADOS-2); **AND**

   The qualified professional's signed and dated conclusion that based upon review of the results of the properly administered ASD evaluation(s) the child meets the diagnostic criteria for ASD under the most recent edition of the American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM); **OR**

2. The qualified professional conducting their own diagnostic evaluation and analyzing the collected data against the ASD diagnostic criteria under the DSM resulting in their determination of an ASD diagnosis.

A licensed physician PCP is always encouraged, to perform their own diagnostic evaluation prior to issuing an ASD diagnosis. No PCP should ever feel pressured or compelled to issue an ASD diagnosis or rely on another qualified professional's diagnostic evaluation instead of their own in conjunction with an ASD diagnosis. If a PCP is not comfortable conducting their own ASD diagnostic evaluation or diagnosis, the PCP should refer the child to another qualified professional for purposes of an ASD evaluation and diagnosis.

Jennifer Brezée, Director
Division of Developmental Disabilities Services

We Care. We Act. We Change Lives.
humanservices.arkansas.gov

Medicaid Member Redetermination Date - Provider Portal

In response to feedback, the Medicaid member redetermination date will now be included in the 271 Response File and displayed on the Provider Portal. This was effective beginning 5/26/2026.

What is the Redetermination Date?

The redetermination date indicates when a member's Medicaid eligibility may end if they do not complete the renewal process. This information is intended to help providers identify members who may be at risk of losing coverage and, if necessary, encourage them to complete their renewal.

Important Note

The redetermination date is provided for informational purposes only and does not guarantee eligibility or payment for services. Please continue to check eligibility prior to providing any service.

Response Details

For electronic eligibility verification via EDI please contact your vendor or review the 270/271 EDI Companion Guide.

- The redetermination date will be sent using HIPAA standards.
- Only redetermination dates that are current or in the future will be returned.
- If multiple redetermination dates exist for different benefit plans, the earliest date will be provided.
- If no redetermination date exists or the date is in the past, no redetermination date will be returned.

Provider Portal Details

The Provider Portal will include a redetermination date field. This can be found on the Secured Provider Portal by navigating to the menu, selecting Eligibility, then Eligibility Verification, completing the necessary search information, and reviewing search results in the Benefit Details section.

Action for Providers

Please review this information when verifying eligibility and consider reminding members to complete their renewal process to ensure continuity of services. If you have any questions or concerns, please contact the Arkansas Medicaid Provider Assistance Center (PAC) call center at 501-376-2211 or 800-457-4454.

PCP Assignment Requests

PCPs can submit PCP assignment requests through the ConnectCare online portal or by fax (501.375.0705). If your clinic doesn't have a ConnectCare online portal account, your AFMC Provider Relations Outreach Specialist can help you get enrolled and ready to use the ConnectCare online portal. Benefits of using the online portal include but aren't limited to email confirmation that the provider's request was received, email confirmation when the assignment is complete, or notifying the sender of the reason why the requested PCP assignment can't be completed, and for improved efficiency.

PCP change form requests submitted through the online portal cannot exceed 90 day retroactive assignment requests. PCP selection/change forms with a PCP assignment request date farther back than 90 days will need to be securely emailed to your AFMC Provider Relations Outreach Specialist and they will work with ConnectCare to determine if the backdated assignment request can be made.

The Do's and Don'ts (PCP Change Form DMS-2609)

This form must be fully completed before a primary care provider (PCP) assignment or change can be made. It will supersede a provider's maximum caseload and/or age restriction. This form can be submitted via fax to 501-375-0705 or via the on-line ConnectCare portal. A copy of the completed DMS-2609 must be kept in the beneficiary's record for auditing purposes.

Do:

1. Print legibly.
2. Check eligibility by name and DOB to ensure the beneficiary's correct Medicaid number is provided.
3. Complete the date of assignment AND the date the beneficiary/legal guardian signs the form. The dates do NOT have to match. If the date of assignment is not indicated, assignment will be made as of the date signed by the beneficiary/legal guardian.
4. Submit the form within 30 days of the beneficiary/legal guardian's dated signature; otherwise, assignment cannot be made.
5. Request assignment within 90 days of the date the form was signed by the beneficiary/legal guardian.
6. Provide an email address if available. It will be used to send the beneficiary educational updates.
7. Use the provider's Medicaid number, not their NPI.
8. Check eligibility to confirm the beneficiary's demographics and compare address to the counties from which your provider accepts Medicaid beneficiaries.
9. Have the beneficiary/legal guardian sign AND print their name in the designated area.
10. Retain a copy of the completed form in the beneficiary's record.

Please note: The Voice Response System (VRS) should be used if a PCP is unassigned on the day of service. That number is 1-800-805-1512.

Do Not:

1. Submit/fax the form to your local DHS office or AFMC ConnectCare if you made the assignment through the Voice Response System (VRS). If retro assignment is needed, reach out to your AFMC Outreach specialist.
2. Submit/fax the form until the demographics of the beneficiary matches one of the counties from which your provider accepts Medicaid beneficiaries. Beneficiaries can update their demographic information by calling the AFMC Service Center at 1-888-987-1200.
3. Request a PCP assignment if the beneficiary has IABP or Medicare Primary – a PCP is not required.
4. Submit/fax the form more than once. If assignment hasn't been made after five days of the initial fax, contact your AFMC Outreach specialist.

Assignment cannot be made:

1. If the form is not legible or the form is altered.
2. Without the signature of the beneficiary/legal guardian.
3. If the beneficiary/legal guardian's name is not printed, in addition to their signature.
4. If the beneficiary/legal guardian's signature is not dated.
5. If changes to the form are made after the beneficiary/legal guardian's dated signature.
6. The provider is not accepting from the beneficiary's residence region.
7. If your provider's medical license isn't updated with Provider Enrollment.

Early Intervention Day Treatment EIDT Psychological or Neuropsychological Testing

Jennifer Brezée, Director
Division of Developmental Disabilities Services
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P: 501.371.2958 F: 501.682.8380

6/8/2026

RE: Early Intervention Day Treatment (EIDT) Providers conducting Psychological or Neuropsychological Testing under the **Diagnostic and Evaluation Services Manual**

Providers,

It has come to our attention that some EIDTs are using their EIDT Medicaid ID# ending in "24" to bill the following procedure codes relating to certain diagnostic and evaluation services:

- 96130
- 96131
- 96136
- 96137

The diagnostic and evaluation services covered by the procedure codes listed above are not covered EIDT services, unless occurring at an Academic Medical Center, and are not listed on the Arkansas Medicaid procedure code table or fee schedule for regular EIDTs; therefore, an EIDT, who is also not a designated Academic Medical Center, cannot be listed as the billing provider on any claim for these procedure codes. These procedure codes can only be billed under one of the following provider types:

- Medicaid Individual Provider Type 19 with a specialty of 62; or
- Medicaid Group Provider Type 44 with a specialty of 62.

Providers should immediately cease billing these procedure codes under their EIDT Medicaid ID#. An EIDT or individual provider that desires to bill Medicaid for the types of diagnostic and evaluation services covered by these procedure codes must enroll with Arkansas Medicaid as a Provider Type 19 licensed professional, such as a Psychologist or Licensed Psychological Examiner-Independent (LPE-I), or, as a Provider Type 44 licensed professional group, in accordance with the Diagnostic and Evaluation Services Medicaid Provider Manual (Diagnostic and Evaluation Services - Arkansas Department of Human Services).

For questions about becoming a Medicaid Provider please see: Become a Provider - Arkansas Department of Human Services.

Let me know if you have any questions about this.

Jennifer Brezée, Director
Division of Developmental Disabilities Services

CMS Moratorium on Newly Enrolling Home Health and Hospice Provider Types

Arkansas Medicaid Provider Enrollment strongly urges all providers to stay current with all Medicare and Medicaid revalidation requests and monitor all notices closely.

Effective May 13, 2026, the Centers for Medicare & Medicaid Services (CMS) established a six-month nationwide moratorium on new Medicare enrollments for specified Home Health and Hospice provider types. This initiative aims to mitigate fraud, waste, and abuse, and CMS retains the authority to extend the restriction in six-month increments.

While this moratorium does not impact currently enrolled agencies, providers must maintain compliant status. Failure to successfully complete Medicare or Medicaid revalidation will result in the termination of Arkansas Medicaid provider agreements, with no option to re-enroll for the duration of the moratorium.

Comprehensive details and regulatory guidance are available in the official CMS FAQ Document.

Current Provider Enrollment Forms

Providers must use the **current versions of all required enrollment forms**, as forms are updated periodically to reflect policy changes, new provider types, and newly required information. Using outdated forms may delay processing or result in returned submissions.

Where to Find Current Forms

- Access current enrollment-related forms on the Provider Enrollment webpage (see "Enrollment-Related Forms from Section V")
- Forms are also available in Section V of the Provider Manual

Health Care Provider Portal Requirement

Use the **Health Care Provider Portal** whenever possible. Information entered directly by providers or authorized staff allows for faster and more accurate processing.

- When completing an application in the Portal, upload only the required documents and enter all requested information directly into the Portal when prompted.
- Only upload required documentation. See the Required Document Finder to learn exactly what is needed with your application.
- Forms that are outdated or can be entered through Portal self-service will be returned.

Submitting Fillable PDF Forms (When Portal Submission Is Not Available)

1. Download and save the required form before opening it in Acrobat Reader.
2. Complete all required fields, sign, and save the finalized document.
3. Upload the document following the instructions in the "How to Upload Documents" job aid.

Using current forms and the Portal whenever possible ensures the most efficient enrollment processing and reduces the risk of returned submissions.

What's New for Arkansas Medicaid Providers

Official notices posted from April 1, 2026 – June 30, 2026. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
Revised Respiratory Syncytial Virus (RSV) Vaccine/Monoclonal Procedures Rate Update	7/6/2026	Procedure Codes
REVISED Dental Rate Increase Retro Effective 9/1/2025	7/1/2026	Procedure Codes
Updated Coverage for Procedure Code J0638	06/26/2026	Prior Authorizations
Ambulance Services Exemptions from Telemedicine Requirements for Triage, Treat and Transport	06/26/2026	Billing Instruction
Federal Revalidation Guidance from CMS	06/19/2026	Provider Enrollment
Prior Authorization required on Procedure Codes A4224 and A4225	06/19/2026	Prior Authorizations
Coverage Added for J0174 and J0175	06/05/2026	Procedure Codes
Updates to Skin Substitute Procedures	06/04/2026	Procedure Codes
REVISED: Continuous Glucose Monitor (CGM) Systems and Supplies – Effective 6/1/2026	06/03/2026	Procedure Codes
Whole Exome Sequencing (WES) Clinical Criteria (CPT 81415, 81416, 81417)	05/22/2026	Procedure Codes
Whole Genome Sequencing (WGS) Clinical Criteria (CPT 81425, 81426, 814271)	05/22/2026	Procedure Codes
Physical Therapist Coverage for Nerve Conduction Study (NCS)	05/07/2026	Procedure Codes
2026 Quarter 2 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion	04/30/2026	Procedure Codes
FQHC and RHC Billing Guidelines for Postpartum	04/24/2026	Billing Instruction
2026 ICD10-PCS Revisions Effective 4/1/2026	04/21/2026	Procedure Codes

Division of Medical Services
P.O. Box 1437, Slot S401, Little Rock, AR 72203-1437
P: (501) 682-8292 F: (501) 682-1197

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: **July 10, 2026**

SUBJECT: **Obstetrics (OB) Services Billing Changes (Global) for PWUCH Members**

I. General Information

To align with Federal Guidelines, Arkansas Department of Human Services has made the following changes *only* for members with a benefit plan of PWUCH (Pregnant Women - Unborn Child) for claims received starting 7/9/2026:

- Postpartum visits are no longer separately reimbursable for PWUCH members.
- To receive reimbursement for postpartum care, providers should bill global OB services for PWUCH members. Refer to Sections II and III below on instructions for when to bill global vs itemized OB services.

Providers that have submitted claims for individual OB services rendered to a PWUCH member and anticipate providing postpartum care are allowed to void claims and rebill for global services if appropriate.

The reimbursement rates for the Global OB codes have been updated in the system effective 7/9/2026. Global OB codes are covered only for PWUCH members and members with Medicare and TPL. Updated rates are reflected in table below (Section II). Claims analysis will be done.

II. Instructions on When to Bill Global OB Services for PWUCH members

The global method of billing should be used when one (1) or more physicians in a group sees the member for a prenatal visit and one (1) of the physicians in the group performs the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.

No benefits are counted against the member's physician visit benefit limit if the global method is billed.

1. One (1) charge for total obstetrical care is billed. The single charge includes the following:
   a) Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to pregnancy.
   b) Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.

c) Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.

d) Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.

2. The global method must be used for the PWUCH when the following conditions exist:

a) At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid member is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.

b) The member was continuously Medicaid eligible for two (2) months or more before delivery and on the delivery date.

If either of the two (2) conditions is not met, the services will be denied.

3. The correct codes for billing Medicaid for global obstetric care are as follows:

Proc	Description	Provider Contract	Rate
59400	VAGINAL DELIVERY WITH CARE BEFORE AND AFTER DELIVERY	ASTSG	$493.15
		CNMW	$1,972.60
		MEDSV	$2,465.75
59410	VAGINAL DELIVERY WITH POST DELIVERY CARE	AS	$248.99
		CNM	$995.98
		MD	$1,244.97
59510	CESAREAN DELIVERY WITH CARE BEFORE AND AFTER DELIVERY	AS	$545.61
		MD	$2,728.03
59515	CESAREAN DELIVERY WITH CARE AFTER DELIVERY	AS	$307.44
		MD	$1,537.18
59610	VAGINAL DELIVERY AND CARE BEFORE AND AFTER DELIVERY AFTER PREVIOUS CESAREAN DELIVERY	AS	$514.00
		CNM	$2,056.01
		MD	$2,570.01
59614	VAGINAL DELIVERY AND CARE AFTER DELIVERY AFTER PRIOR CESAREAN DELIVERY	AS	$267.41
		CNM	$1,069.65
		MD	$1,337.06
59618	CESAREAN DELIVERY AND CARE BEFORE AND AFTER DELIVERY FOLLOWING ATTEMPTED VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY	AS	$551.05
		MD	$2,755.27
59622	CESAREAN DELIVERY WITH CARE AFTER DELIVERY FOLLOWING VAGINAL DELIVERY ATTEMPT AFTER PREVIOUS CESAREAN DELIVERY	AS	$318.28
		MD	$1,591.38

NOTE: Rates are subject to change.

III. Instructions on When to Bill Itemized OB Services for PWUCH members

Use this method only when either of the following conditions exists:

- Less than two months of antepartum care was provided
- The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.

Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section II of applicable provider manual. The visits for antepartum care will not be counted against the member's annual physician benefit limit. Date-of-service spans shall not include any dates for which the member was ineligible for Medicaid.

Bill Medicaid for the delivery with the applicable procedure code from the following table:

Proc	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

Postpartum visits will not be reimbursed for PWUCH members.

OFFICIAL NOTICE

TO: Health Care Providers – All Providers

DATE: June 25, 2026 REVISED July 7, 2026

SUBJECT: Respiratory Syncytial Virus (RSV) Vaccine/Monoclonal Procedures Rate Update

I. General Information

The Arkansas Department of Human Services has updated the rates for Respiratory Syncytial Virus (RSV) Administration Fee for Children, effective 7/1/2026.

Proc Code	Mod	Description	Amount
90380	EP TJ or SL	RSV MONOC ANTB SEASN .5ML IM	$19.54
90381	EP TJ or SL	RSV MONOC ANTB SEASN 1 ML IM	$19.54
90382	EP TJ or SL	RSV MONOC ANTB SEASN .7ML IM	$19.54
90678	EP TJ or SL	RSV VACC PREF BIVALENT IM	$19.54

TO: EARLY INTERVENTION DAY TREATMENT (EIDT) AND PROVIDER-LED ARKANSAS SHARED SAVINGS ENTITY (PASSE) PROGRAM PROVIDERS

RE: EIDT PROVIDERS CONDUCTING PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TESTING UNDER THE DIAGNOSTIC AND EVALUATION SERVICES MANUAL

It has come to our attention that some EIDTs are using their EIDT Medicaid ID number ending in "24" to bill the following procedure codes relating to certain diagnostic and evaluation services:

- • 96130
- • 96131
- • 96136
- • 96137

The diagnostic and evaluation services covered by the procedure codes listed above are not covered EIDT services, unless occurring at an Academic Medical Center. These codes are not listed on the Arkansas Medicaid procedure code table or fee schedule for regular EIDTs. An EIDT, who is also not a designated Academic Medical Center, cannot be listed as the billing provider on any claim for these procedure codes. These procedure codes can only be billed under one of the following provider types:

- • Medicaid Individual Provider Type 19 with a specialty of 62; or
- • Medicaid Group Provider Type 44 with a specialty of 62.

Providers should immediately cease billing these procedure codes under their EIDT Medicaid ID numbers. An EIDT or individual provider that desires to bill Medicaid for the types of diagnostic and evaluation services covered by these procedure codes must enroll with Arkansas Medicaid as a Provider Type 19 licensed professional, such as a Psychologist or Licensed Psychological Examiner-Independent (LPE-I), or, as a Provider Type 44 licensed professional group, in accordance with the Diagnostic and Evaluation Services Medicaid Provider Manual (https://humanservices.arkansas.gov/wp-content/uploads/DIAGEVAL_II.docx).

For questions about becoming a Medicaid Provider please see: https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/

TO: FEDERALLY QUALIFIED HEALTH CENTER (FQHC) AND PHYSICIAN PROVIDERS

RE: ARKIDS COPAY BYPASS

It was identified that a copayment was paid to providers by beneficiaries who participate in the ARKids benefit plan when Modifier 33 (PREVENTIVE SERVICES) was billed and paid. Copay was not required.

A mass adjustment for these claims will be conducted to pay the impacted providers this copayment amount and is to be reimbursed to the beneficiaries by the providers.

TO: QUALIFIED HEALTH PLAN, MEDICARE HEALTH ADVANTAGE PLANS, DDS NON-MEDICAID PROVIDERS, AND REGISTERED, NON-CREDENTIALED PROVIDERS

RE: FEDERAL REVALIDATION REQUIREMENTS FROM CMS

With recent CMS guidelines shifting enrollment requirements for various provider types, Provider Enrollment encourages ALL providers to remain aware and watchful for revalidation letters and other notifications. Utilize the provider portal as a resource to remain current on changes that may impact your enrollment.

Guidelines from the Centers for Medicare and Medicaid Services (CMS) requires your provider type to revalidate. Look for the release of a revalidation letter in the coming weeks. Beginning May 26, 2026, providers can review their revalidation date in the Health Care Portal.

Who Must Revalidate

- Qualified Health Plan,
- Medicare Health Advantage Plans,
- DDS Non-Medicaid Providers, and
- Registered, Non-Credentialed Providers

These providers are required to complete a revalidation application to maintain continued enrollment. Future revalidation will be required every five (5) years for these Low Risk provider types moving forward.

Portal Updates

When logging into the portal on or after May 26, providers will see a revalidation link along with their assigned revalidation deadline date. Providers will have 90 days to complete revalidation, although Provider Enrollment encourages completion within 60 days as best practice in case of any processing delays.

Required Documentation

- W 9 (2024 version)
- IRS Letter
  - Required for the enrolling provider and any listed entity owners
- EFT Form and Bank Letter
  - Only required if updating EFT information

Please note:

- Provider Type 95: DO NOT upload form DMS-7708, Practitioner Identification Number Request. All required information will be captured when completing revalidation through the Health Care Portal.
- All revalidating providers are strongly encouraged to review and update their demographic information to prevent revalidation applications being returned for correction. Form DMS-673, Address Change Form, is available for download from the Provider Enrollment Information webpage (https://humanservices.arkansas.gov/wp-content/uploads/DMS-673.pdf) or in Section V of your provider manual.
- Failure to complete revalidation will result in termination as an Arkansas Medicaid provider.

For questions concerning revalidation, visit the Provider Enrollment Information webpage at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/ or contact Arkansas Medicaid Provider Enrollment at (800) 457 4454.

TO: PROSTHETICS AND PRIVATE DUTY NURSING PROVIDERS	RE: CGM ON HOLD - UPDATES WILL BE FORTHCOMING

Due to the Public Health Rule Committee review, the previously communicated guidance for Continuous Glucose Monitors (CGM) in ON-018-26 has been put on hold. Updates will be provided as soon as they become available.

PCMH

Important Information for the 2025 Performance-Based Incentive Payment (PBIP) Reconsideration Period

The reconsideration period for Arkansas Medicaid PCMH 2025 Performance-Based Incentive Payment (PBIP) Measures and Low Performance Core Metrics will begin on June 25, 2026. To request reconsideration, practices must submit a written request by USPS mail in accordance with the guidance outlined in the PCMH manual.

Please mail all reconsideration requests to:

Arkansas Department of Human Services,
Division of Medical Services, Health Care Innovation
Attention PCMH – Reconsideration
P.O. Box 1437, Slot S425
Little Rock, AR 72203

Your written request must be postmarked no later than 8/25/26 to be eligible for reconsideration review. Please note that review of supporting documentation will not begin until your written request has been received. No exceptions will be made for requests submitted after the final postmark deadline. Because of known delays with USPS, please also email your written request to PCMH@afmc.org.

Important Information

- Quarterly reports will be available on the QualityCare Insight (QCI) portal on 6/25/2026.
- Reports will include current PBIP standings for 2025 incentive measures and passing rates for all Low Performance Core Metrics.
- This will be the final quarterly report for the 2025 performance period prior to the final results in March of 2027.
- The release of the 6/25/2026 quarterly report will begin the reconsideration request submission timeline.
- The reconsideration and appeal process will follow the new 60-day rule.
- The QCI portal will be open on 6/26/2026 for submission of supporting documentation related to PBIP measures.
- PCMHs will not be permitted to submit additional supporting documentation after the portal closes.

Guidance for PCMHs Failing Core Measures

PCMHs that fail one or more core measures and wish to request reconsideration must follow the guidance below:

- Access the Beneficiary Metric Report for the applicable core metrics.
- Submit supporting documentation through secure email PCMH@afmc.org.
- Core measure reconsideration requests must be submitted via USPS mail this year and not through the QCI portal.
- PCMHs failing any core metrics after the reconsideration period will not be eligible for PBIP payment.

If you need assistance with your PBIP reconsideration request, please contact your AFMC Outreach Specialist. For assistance with QualityCare Insight functionality, please email ARQCISupport@gdit.com.

PCMH 9-month activities - Due by Sept. 30, 2026

241.00 Activities Tracked for Practice Support (PBPM Care Coordination Payment)

Activities for the 2026 Performance Period

All PCMHs must complete the following activities, complete the required attestations, and submit supporting documentation in the Quality Care Insight (QCI) provider portal by 9/30/2026 to be eligible for PBPM care coordination payments.

Activity	9-Month
H. Model Fidelity/Healthy Steps Participation	✓
I. Patient Literacy Assessment Tool	✓
J. Patient and Family Engagement	✓
K. Care Instructions/After Visit Summary	✓
L. Social Determinants of Health	✓

Activity H: Model Fidelity/ACT 513 Participation

Activity H Deadline: 9/30/2026 Model Fidelity/Healthy Steps Participation
This Activity is only for practices recognized as having completed training and are on track to achieve or have achieved model fidelity as defined in ACT 513. **Currently the only model recognized for the 2026 performance period is HealthySteps** 1. Attest that your practice participates in the above recognized program model. 2. Upload the annual site report the practice must submit to HealthySteps to the QCI portal.

Activity I: Patient Literacy Assessment Tool

Activity I Deadline: 9/30/2026 Patient Literacy Assessment Tool
1. Choose any health literacy tool and administer the screening to at least 75 beneficiaries (enrolled in the PCMH program) or their caregivers. Returning practices should select 75 beneficiaries that have not had a health literacy screening previously. 2. A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists. 3. Provide an example of the tool used to assess health literacy. 4. Provide a description of the overall results of the assessment. 5. Develop and describe a plan to help low health literacy beneficiaries understand instructions and education materials. 6. Practices must document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity J: Patient and Family Engagement

Activity J Deadline: 9/30/2026 Patient and Family Engagement
1. Indicate if the practice has an established process for patient and family engagement. a. Describe * The method used to engage patients and families in decisions regarding the patient's care * Provide examples of tools used in the practice to engage patients and families in the patients' care. * If the practice is new to the PCMH program and does not have a current process for patient and family engagement, explain how a process will be developed, including time line to achieve within the first year. b. Information on patient and family engagement may be found on the CMS website at: https://www.cms.gov/Medicare/QualityInitiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-StrategySummary.pdf 2. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request

Activity K: Care Instructions/After Visit Summary

Activity K Deadline: 09/30/2026 Care Instructions/After Visit Summary
1. Create an after-visit summary from the patient's last visit. The summary should include relevant and actionable information, including diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions 2. Provide the patient a copy of the after-visit summary based on the patient's preferred method of delivery. Methods by which a patient may choose to receive his/her after-visit summary include the following: a. The patient may receive a paper copy after the of the summary after his/her visit, prior to leaving the clinic. b. A copy of the summary may be mailed to the patient at the address listed in the record within three days of the visit, or completion of any lab test related to the visit c. An electronic copy of the summary may be made available to the patient via a patient portal 3. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request.

Activity L: Social Determinants of Health

Activity L Deadline: 09/30/2026 Social Determinants of Health
Respond to the following questions in the QCI provider portal: 1. Does your practice screen for social determinants of health? 2. If yes, what type of screening tool is used? Please upload a copy of the tool in the QCI provider portal 3. If yes to question 1, what is the process for analyzing the data received and how is it used? 4. If no to question 1, what are your plans to implement screening for social determinants of health including a timeline to implement in the first year? 5. Practices are to document completion of this activity via the QCI provider portal and attest that the described activity has been completed and that proper evidence of such can be provided upon request. 6. Do you feel confident as a practice or are you able to make appropriate referrals in those areas identified?

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.

Director, Provider Relations

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

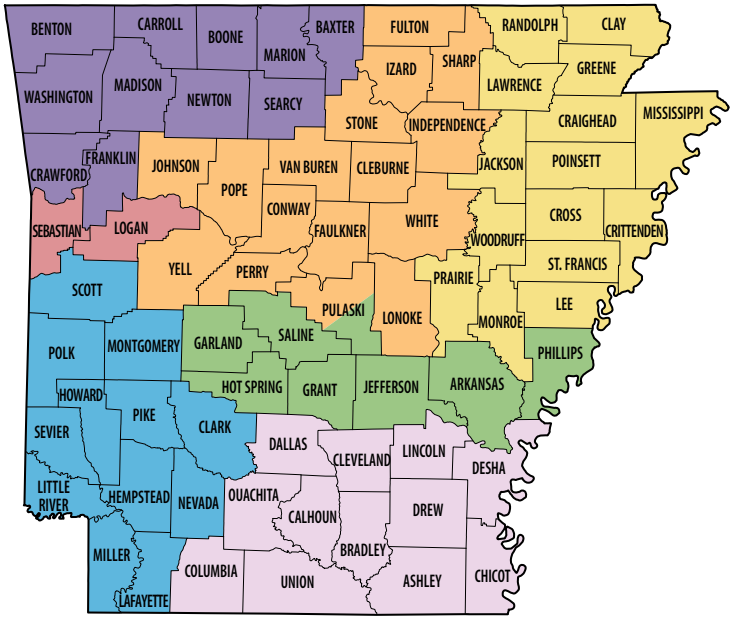
Provider Relations.....
providerrelations@afmc.org

Toni Humphry **501-545-7873**
thumphry@afmc.org

Sonja Savage **501-554-1328**
sonja.savage@afmc.org

Supervisor, Outreach Logistics

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



07/20/2026

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

IN THIS ISSUE OF ARMedicaid

ARKANSAS PROVIDER MEDICAID UPDATE

Q1 SFY 2027
(July–September 2026)

- Autism Spectrum Disorder Diagnosis Requirements for Primary Care Providers
- CMS Moratorium on Newly Enrolling Home Health and Hospice Provider Types
- Medicaid Member Redetermination Date - Provider Portal
- Section IV Affiliation/Disaffiliation Form

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