ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

# ARKANSAS PROVIDER MEDICAID UPDATE

Q2 SFY 2026
(October–December 2025)

## 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.



## Maternal Outreach and New Toolkits for Newly Enrolled Beneficiaries, Pregnancy, and New Moms

AFMC has partnered with AR Medicaid to provide new digital resources for Medicaid beneficiaries to help them better understand their benefits. All information is easy to read and divided into easily searchable sections.

The new Welcome Packet is designed to help newly enrolled beneficiaries navigate Medicaid. It explains what Medicaid is, what it covers, how people can apply for and renew coverage, and how to find providers. It also provides recommendations for what people should do once they are enrolled, such as schedule a wellness visit and get needed vaccines. The Welcome Packet also includes a list of helpful numbers and websites.

The Pregnancy and New Mom Toolkit gives women information about what Medicaid covers during and after pregnancy as well as important health information, including testing for sexually transmitted infections and preeclampsia.

For those who want paper copies, all materials mentioned above have been made into a PDF that can be downloaded, saved, and printed.

The toolkit is part of a broader effort by Medicaid to educate and support pregnant women and new moms that includes two new outbound calling campaigns. The first is the ARHOPE program (Arkansas Healthy Outcomes and Pregnancy Education). AFMC call center agents are calling women newly enrolled in a pregnancy-related Medicaid category to make sure they have an OBGYN or prenatal care provider and to help them find one if they do not have one already. Agents may call a provider's office to do a warm transfer of a beneficiary who is looking for a provider. If your office gets a call from our agents who are transferring a beneficiary, we encourage you to accept the call and schedule an appointment. The goal of this program is to get more women in Arkansas to access prenatal care as early as possible. AFMC is working with Arkansas Medicaid to expand who they call to include women in all Medicaid categories.

AFMC has partnered with AR Medicaid to call postpartum women who are at risk of losing their coverage within the next 30-60 days. This is our Maternal Outreach program. During these

calls, agents are educating beneficiaries about why they may be losing coverage, what steps they need to take to keep it, and what other coverage options are available.


# Non-Emergency Transportation (NET) Frequently Asked Questions

What is Non-Emergency Transportation (NET)? Medicaid beneficiaries may be eligible to get a ride to and from their primary care provider (PCP) appointments or other Medicaid-covered medical and non-medical services. Beneficiaries don't have a copay for non-emergency transportation. NET can accommodate ambulatory beneficiaries, beneficiaries with disabilities, and beneficiaries who use wheelchairs. It is a curb to curb, shared ride program.

Who can use NET? Beneficiaries qualify for NET if they are on Medicaid or ARKids First-A (minor children must be accompanied by an adult, preferably a parent or guardian). Beneficiaries must not have any other way to get to their appointment.

Beneficiaries cannot use NET if they:

- Are in a nursing home
- Are a qualified Medicare beneficiary (QMB)
- Are in an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Are enrolled in the ARKids First-B benefit plan

What if a beneficiary has ARHome coverage? If beneficiaries have ARHome coverage, they receive 8 trips automatically every January (4 round trips or 8 one-way trips). If a beneficiary needs more than 8 trips, they can request more trips by calling 1-844-223-0293. The NET

Resource Specialist will ask them questions and extend the number of trips they may need. The NET Resource Specialist will provide a certification number, which will be needed by their transportation broker.

How do beneficiaries schedule a NET ride? Beneficiaries must call the NET broker in their region at least 48 hours (two whole days) before their appointment. Weekends and holidays don't count toward the 48 hours. This means if their appointment is on a Thursday, the beneficiary would need to call and schedule their ride on Tuesday. Their transportation broker will have a list of questions to ask the beneficiary to determine if they are eligible for transportation services.

When they call, they need to:

- Have their Medicaid ID ready;
- Tell the broker why they need a ride;
- Provide their name, address, and phone number of the health care provider;
- Provide the day and time of the appointment.

NET brokers take reservations from 8 a.m. to 5 p.m. Monday through Friday. To find out who the NET transportation broker is for their region, beneficiaries should call the Medicaid Transportation Help Line toll-free at 1-888-987-1200, option 1. If they have access to the internet, they can visit AFMC.org and click on the NET broker map. They can request a NET brochure by calling the NET helpline at 1-888-987-1200, option 1.

What if their ride doesn't show up? If this happens, the beneficiary needs to call their transportation broker to report the problem. They can also call the NET Help Line at 1-888-987-1200, option 1.

What is the NET Help Line? The NET Help Line is a toll-free number (1-888-987-1200, option 1) that helps beneficiaries with their questions, comments, complaints, and suggestions about the NET program. The Help Line will **NOT** arrange rides for beneficiaries, but they can help them determine who their broker is.

Beneficiaries can go to a specialist outside their local area if they have a referral from their PCP. **The NET broker is responsible for informing the beneficiary that they must obtain a referral from the PCP.** The DMS-2610 PCP referral form must be faxed to the NET broker by the PCP.

The NET broker must provide transportation to a beneficiary's PCP who is located outside the broker's region when:

- The PCP is located in a county adjacent to the county in which the beneficiary resides, or in the county that adjoins a county that is adjacent to the county in which the beneficiary resides.

The NET broker must provide transportation to a medical provider who is located outside the broker's region when:

- The beneficiary's assigned Medicaid PCP has made a referral to a specific provider for a medically necessary service; however, the broker is not responsible for transporting beneficiaries more than fifty (50) miles beyond state of Arkansas boundaries.
- The beneficiary's assigned Medicaid PCP has made a referral to a medically necessary service, and sufficient medical resources are not available in the beneficiary's county; however, the broker is not responsible for transporting beneficiaries more than fifty (50) miles beyond state of Arkansas boundaries.

Where do I find more information to share with Medicaid beneficiaries? Visit the Non-Emergency Transportation (NET) webpage to learn more. AFMC.org

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

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

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

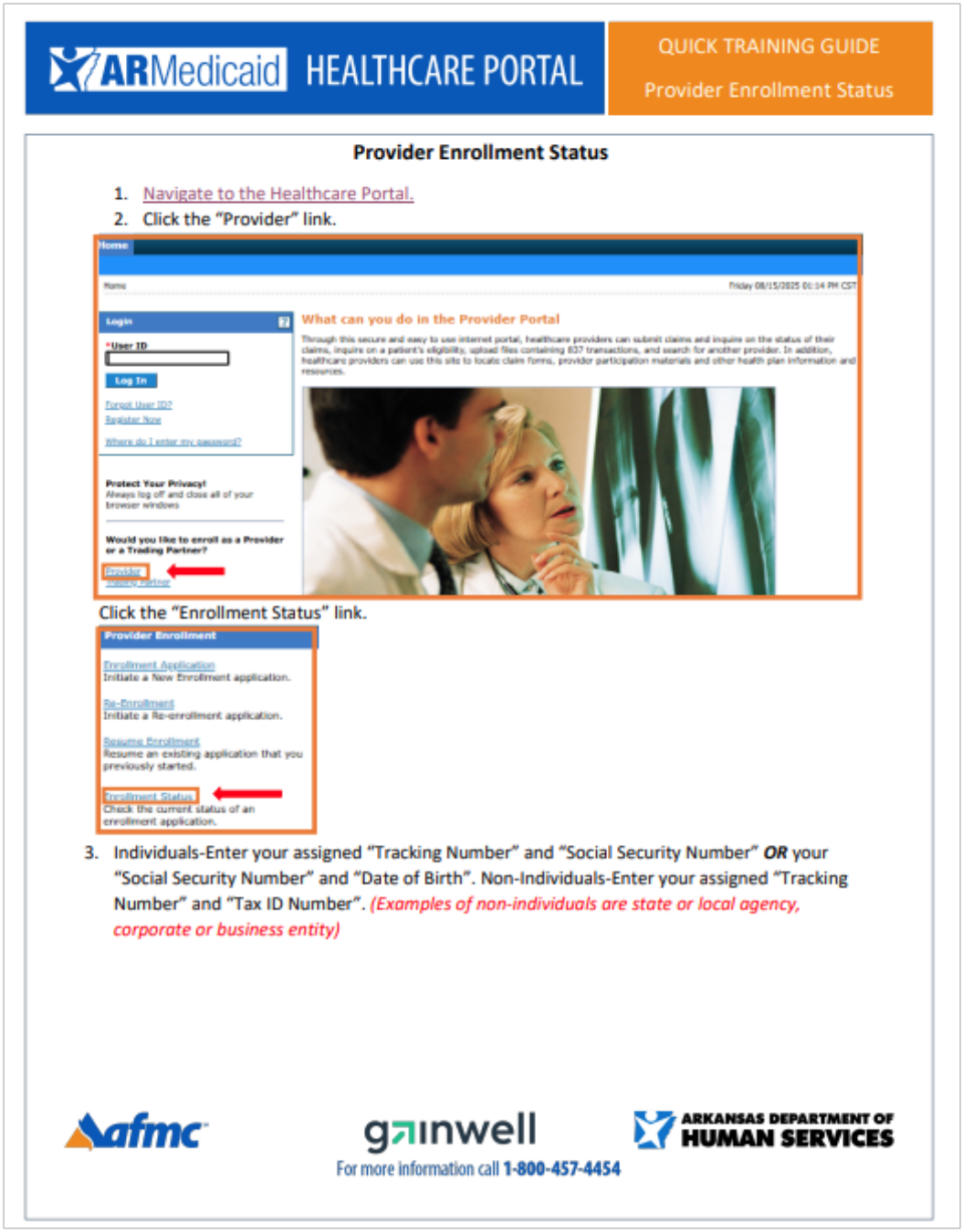
ARKids First-B beneficiaries receive preventive health care screens and treatment options within covered benefits through age 18. Covered services provided to ARKids First-B beneficiaries are within the same scope of services provided to ARKids First-A beneficiaries. However, some ARKids First-B services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

# Name Change Guide for Arkansas Medicaid Providers

This new guide is intended for individual providers, provider groups, and agencies who need to update their name with Arkansas Medicaid. It outlines the verification process, required documentation, and submission instructions. You can locate the guide here.

# Quick Track Training Guide for Provider Enrollment Status

This new guide is intended for individual providers, provider groups, and agencies needing to check their Arkansas Medicaid provider enrollment status. You can locate the guide here.



ARMedicaid HEALTHCARE PORTAL

QUICK TRAINING GUIDE

Provider Enrollment Status

**Provider Enrollment Status**

1. Navigate to the Healthcare Portal.
2. Click the "Provider" link.

Home

What can you do in the Provider Portal

Login

*User ID

Log In

Forgot User ID?

Register Now

Where do I enter my password?

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider or a Trading Partner?

Provider

Trading Partner

Click the "Enrollment Status" link.

Provider Enrollment

Enrollment Application
Initiate a New Enrollment application.

Re-Enrollment
Initiate a Re-enrollment application.

Resume Enrollment
Resume an existing application that you previously started.

Enrollment Status
Check the current status of an enrollment application.

3. Individuals-Enter your assigned "Tracking Number" and "Social Security Number" ***OR*** your "Social Security Number" and "Date of Birth". Non-Individuals-Enter your assigned "Tracking Number" and "Tax ID Number". *(Examples of non-individuals are state or local agency, corporate or business entity)*

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For more information call **1-800-457-4454**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

SAVE THE DATE!

#ARMediCon

# 2025 ARKANSAS MEDICAID EDUCATIONAL CONFERENCE

**FOR PHYSICIANS, NURSES, OFFICE MANAGERS, BILLERS AND HOSPITALS**

# December 9, 2025

## BENTON EVENT CENTER

IN-PERSON AND VIRTUAL EVENT

REGISTRATION LINK COMING SOON

**afmc.org/medicon**

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# Patient-Centered Medical Home (PCMH) Enrollment

**Enroll now for the 2026 AR Medicaid Performance Period**

Open enrollment:
October 6, 2025 – November 17, 2025

## PCMH Activities Tracked for Practice Support

241.000 Activities Tracked for Practice Support

**Activities for the 2025 Performance Period**

To be eligible for practice support, all PCMHs must meet all activities by the following deadlines, complete the attestations, and submit supporting documentation in the Quality Care Insight (QCI) provider portal.

- 12-month activities by 12/31/2025

For information on remediation, please refer to the PCMH Provider Manual.

| Activity | 3-Month | 6-Month | 12-Month |
|---|---|---|---|
| F. Track third available appointment | | | ✓ |
| G. Care Plans for High Priority Patients | | | ✓ |
| H. Patient Literacy Assessment Tool | | | ✓ |
| I. Patient and Family Engagement | | | ✓ |
| J. Care instructions for High Priority Patients | | | ✓ |
| K. Social Determinants of Health | | | ✓ |

## Activity F: Track third next available appointment

| Activity F Deadline: 12/31/2025 |
|---|

1. Perform this activity by:

- Using either a manual or an electronic tool to track the third next available appointment for the following:
    - New patient appointment
    - Routine exam
    - Return visit exam

  According to the Institute for Healthcare Improvement (IHI), "The data collection can be done manually or electronically. Manual collection means looking in the schedule book and counting from the "index" (day when the "dummy" appointment is requested) to the day of the third available appointment. Some electronic scheduling systems can be programmed to compute the number of days automatically."

  An example of a tool may be found by clicking on the link: Third Next Available Appointment: A Reference Guide (h1ccp.com)
- Collect data:
- On the same day of the week, once a week, sample all physicians.
- "Count the number of days between a request for an appointment (e.g., enter dummy patient) with a physician and the third next available appointment for a new patient physical, routine exam, or return visit exam. Count calendar days (e.g. include weekends) and days off. Do not count any saved appointments for urgent visits (since they are "blocked off" on the schedule.)" (IHI, 2021)
- Record fulfillment of the third next available appointment for physicians sampled.
- Report the average number of days for physicians sampled. 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 G: Care Plans for High Priority Patients

| Activity G Deadline: 12/31/2025 |
|---|

- At least 80% of high-priority patients have care plans and/or notes contained in the medical record that include the following elements:
- Documentation of the patient's appropriate problem list
- The problem list should include any active, significant clinical condition (chronic and/or acute)
- Each visit related encounter should include a list of current problems (chronic and/or acute)
- Assessment of progress to date
- Documentation and assessment of each problem (stability or change of condition)
- Each problem noted in the problem list must have an assessment as well as a status of the problem/diagnosis in the plan or in the note. For example, "diabetes well controlled based on HbA1c 6.7 and per patient's compliance with prescribed medication" is sufficient.
- If a problem noted in the problem list is no longer an active problem, a status such as "resolved" should be indicated.
- If a specialist follows the patient, the most recent findings should be documented, if available.
- Plan of Care
- The documentation should include a specific plan of care related to the problem. For example, "continue Lisinopril 5mg daily", "ordering labs", "referral to OT/PT for evaluation and treatment", "continue therapy sessions", "prescribed Vyvanse 30 mg daily", are acceptable.
- Instruction for follow-up
- The documentation should include the timing of future follow-up visits (related to the problem)
- If multiples problems are addressed, a single clearly defined future visit (return to clinic date) is acceptable. For example, "return to office in 6 months" is acceptable; "return if no improvement or as needed" is not acceptable.
- If problems/conditions are followed by a specialist, the timing of the follow up visit with the specialists should be noted. For example, "follow up with endocrinologist in 6 months" is acceptable; "follow up with endocrinologist" is not acceptable.
- A minimum of two care plans should be completed within a 12-month period and submitted for validation review.
- Documented update to the plan of care which would include active problems
- For new patients: initial care plan and one update (in person or phone call)

- For established patients: one care plan update must be completed by a face-to-face visit and one update may be completed via a phone call.
- Addendums to the care plans are acceptable if completed within a reasonable period of no more than two weeks after the care plan has been created or updated.
- Indicate if at least 80% of the top 10% of high-priority patients have a first and second care plan in the medical record. Each attested care plan includes all required elements listed in number 1.
- For validation audit, 20% of the top 10% of high-priority patients with a first and second care plan, will be randomly selected for review of care plans. To pass this activity, at least 80% of the care plans must include all the required elements listed in number 1.
- PCMHs that successfully pass two consecutive years of care plan validation audits without going into remediation will be eligible for a "Fast Track" audit.
- The Fast Track audit includes:
- Sample audit of five care plans
- Sample audits will be conducted at the same time as regular care plan validation audits and for the same performance period
- The PCMH must successfully pass the audit with at least an 80% total score
- The scoring methodology will remain the same for the sample audit
- If the practice passes the Fast Track audit, no further care plan audit will be required for the performance period.
- If a practice fails the sample Fast Track audit, care plan validation will revert to the standard audit process, and the PCMH will be required to submit the full 20% of care plans randomly selected for high-priority patients with a first and second care plan.
- If the PCMH passes the secondary audit, the PCMH will remain in good standing and will be eligible for the Fast Track audit in the upcoming performance period.
- If the PCMH does not meet the 80% target for the secondary audit, the PCMH will be required to follow the remediation process as stated in Section 242.000 of the PCMH Provider Manual and will not be eligible for the Fast Track audit for the upcoming year.
- Scoring methodology:
- Each element of the care plan will be scored accordingly, with a total of eight possible points per High Priority Patient (HPP). The scoring methodology is the same for a regular care plan audit and a Fast Track audit.

| Care Plan Element | Point Value (Care Plan 1) | Point Value (Care Plan 2) | | Total Possible Points per HPP |
|---|---|---|---|---|
| Problem list | 1 | 1 | | 2 |
| Assessment of problems | 1 | 1 | | 2 |
| Plan of Care | 1 | 1 | | 2 |
| Instruction for follow up | 1 | 1 | | 2 |
| Total possible points per HPP | 4 | 4 | | 8 |

- 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 H: Patient Literacy Assessment Tool

| Activity H Deadline: 12/31/2025 |
|---|
| • 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.<br>• A list of health literacy tools suggested by the UAMS Center for Health Literacy may be obtained from the PCMHs AFMC Outreach Specialists.<br>• Provide an example of the tool used to assess health literacy.<br>• Provide a description of the overall results of the assessment.<br>• Develop and describe a plan to help low health literacy beneficiaries to understand instructions and education materials.<br>• 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 I: Patient and Family Engagement

| Activity I Deadline: 12/31/2025 |
|---|
| The purpose of this activity is to establish proactive communication and partnered decision-making between providers, patients, families, and caregivers. It is about building a relationship that is based on trust and inclusion of individual values and beliefs.<br>1. Indicate if the practice has an established process for patient and family engagement.<br>a. Describe:<br>i. The method used to engage patients and families in decisions regarding the patient's care<br>ii. Provide examples of tools used in the practice to engage patients and families.<br>iii. If the practice does not have a current process for patient and family engagement, explain future plans to develop a process.<br>b. Information on patient and family engagement may be found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/Person-and-Family-Engagement-Strategy-Summary.pdf<br>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 J: Care Instructions for High Priority Patients

| Activity J Deadline: 12/31/2025 |
|---|

1. Compile relevant and actionable information including diagnosis, medication list, tests and results (if available), referral information (if applicable), and follow up instructions.
2. Create an after-visit summary of the information from patient's last visit.
3. The patient will receive 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 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 made available to the patient via a patient portal
4. 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: Social Determinants of Health

| Activity K Deadline: 12/31/2025 |
|---|

The purpose of this activity is to gather information regarding whether a PCMH screens its beneficiaries for Social Determinants of Health (SDOH). For the 2025 performance period, not screening for SDOH will cause a PCMH to not pass this activity.

A PCMH must 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?
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 as a practice feel confident or are you able to make appropriate referrals in those areas identified?

Click here for Table of Contents 2025 PCMH Program Policy Addendum.

# What's New for Arkansas Medicaid Providers

Official notices posted from July 1, 2025 – September 30, 2025. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

| Title | Posted Date | Category |
|---|---|---|
| 2026 ICD10-CM/PCS Revisions Effective 10/1/2025 | 09/26/2025 | Procedure Codes |
| Coverage for Procedure Codes 61736 and 61737 | 09/10/2025 | Procedure Codes |
| REVISED 2025 Quarter 3 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion | 09/04/2025 | Procedure Codes |
| REVISED: New Edit for 340B Medical Billing | 07/28/2025 | Billing Instruction |
| Updates to Wheelchair Accessories Procedure Codes E1028 and E1032-E1034 | 07/21/2025 | Procedure Codes |
| Coverage for Procedure Codes 58300 and 58301 | 07/17/2025 | Procedure Codes |
| Inpatient Claims and Use of Condition Codes | 07/15/2025 | Condition Codes |
| 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 |

**TO: Health Care Providers – Certified Nurse-Midwife (CNM), Nurse Practitioner, and Physician**

**DATE: July 17, 2025**

**SUBJECT: Coverage for Procedure Codes 58300 and 58301**

The Arkansas Department of Human Services has updated coverage for the procedure codes and contracts identified below, retroactive to 7/1/2024.

This update only affects non-Family Planning indications. For Family Planning related billing please refer to the Procedure Code tables and billing policy guidelines.

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

| Proc | Description | Provider Contract | Gender |
|---|---|---|---|
| 58300 | INSERT INTRAUTERINE DEVICE | CNMW, MEDSV, NURSP | F |
| 58301 | REMOVE INTRAUTERINE DEVICE | CNMW, MEDSV, NURSP | F |

If you have questions regarding this notice, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211.

**TO: Health Care Providers – Hospital**

**DATE: July 15, 2025**

**SUBJECT: Inpatient Claims and Use of Condition Codes**

Arkansas Department of Human Services has updated the system for billing Condition Codes to better align with the National Uniform Billing Codes (NUBC) manual. This update will allow Type of Bill (TOB) 111 or 112 to be billed with any condition code that is applicable to the member's condition. Refer to the NUBC UB-04 Uniform Billing Manual for a list of Condition codes and additional instructions.

Claims analysis will be performed to identify and reprocess any claims in the past year that may have been processed prior to this change being implemented.

If you have questions regarding this notice, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211.

# Messages for AR Medicaid Providers

**Messages for Remittance Advices dated September 25, 2025 – October 2, 2025**

| TO: NURSE PRACTITIONER PROVIDERS | RE: PROCEDURE CODE J0129 COVERED UNDER NURSE PRACTITIONER CONTRACT |
|---|---|

The following has been added to the NURSP contract retro effective 9/1/2024:

PROC DESCRIPTION PRIOR AUTH

J0129 ABATACEPT INJECTION Y

Claims analysis will be completed.

| TO: PHYSICIAN PROVIDERS | RE: PLACE OF SERVICE (POS) UPDATES FOR PROCEDURE 01215 |
|---|---|

Effective 10/01/2024, POS 19 and 22 have been added to procedure 01215 [ANESTH REVISE HIP REPAIR ] in the ANSTH contract.

Claims analysis will be performed to identify any claims that may have denied for these POS prior to the update being made.

| TO: ALL PROVIDERS | RE: ELECTRONIC FUNDS TRANSFER (EFT) VALIDATION NOW INCLUDES CONFIRMATION OF MICRO-DEPOSITS |
|---|---|

Arkansas Medicaid is introducing a new validation step in the Electronic Funds Transfer (EFT) enrollment process. Now, when providers enroll in EFT, Arkansas Medicaid will send two micro-deposits to the provider's designated bank account. Once these deposits are made, providers will receive an "Attention" banner after logging into the provider portal. Providers will click the "EFT Validation" link and then enter the exact amount of the deposits sent by Arkansas Medicaid to confirm enrollment.

The "Attention" banner will remain visible for 14 days after the micro-deposits are sent. Providers will be given three attempts to enter the correct deposit amounts. If all three attempts are unsuccessful, please contact the Help Desk at 1-800-457-4454 for assistance. A job aid has been added to the Provider Training Information webpage at Ar.gov/DMSProviderTraining We appreciate your cooperation in enhancing the security of EFT transactions.

**Messages for Remittance Advices dated September 18, 2025 – September 25, 2025**

| TO: HOSPITAL AND PHYSICIAN PROVIDERS | RE: COVERAGE FOR PROCEDURE CODES 61736 AND 61737 |
|---|---|

The Arkansas Department of Human Services has added coverage for the procedure codes identified below retroactive to 3/1/2024.

The codes will require Prior Approval and will be covered under provider contracts: Assistant Surgeon (ASTSG), Medical Services (MEDSV), and Outpatient (OUTPA).

61736 LITT ICR 1 TRAJ 1 SMPL LES

61737 LITT ICR MLT TRJ MLT/CPLX LS

Claims analysis will be performed to identify any claims that may have denied prior to coverage being added.

| TO: PHYSICIAN PROVIDERS | RE: PLACE OF SERVICE UPDATES FOR PROCEDURE CODE 00797 |
|---|---|

The Arkansas Department of Human Services has updated POS in the ANSTH contract to include 19, 22, & 24 for procedure 00797 [ANES IPER UPR ABD GSTR PX MO].

Claims analysis will be performed.

| TO: AMBULATORY SURGICAL CENTER (ASC), INDEPENDENT LAB, INDEPENDENT RADIOLOGY, NURSE PRACTITIONER, PHYSICIAN, PODIATRIST, PROSTHETICS (INCLUDES DME AND ORTHOTICS), AND VISUAL CARE PROVIDERS | RE: PROFESSIONAL CROSSOVER CLAIMS DUPLICATED IN ERROR WILL BE RECOUPED |
|---|---|

A recent review found professional crossover claims billed by providers directly to Medicaid were paid in error. This is a duplication as Medicaid is the payer of last resort. As a result, these funds will be recouped.

There is no need to rebill as these claims have already been paid. No action is needed from the provider.

| TO: HOSPITAL, NURSE PRACTITIONER, AND PHYSICIAN PROVIDERS | RE: PROCEDURE CODES J9266 RATE UPDATE |
|---|---|

The Arkansas Department of Human Services has updated the rate for procedure code below retroactive to 1/1/2025 for the MEDSV, NURSP, and OUTPA provider contracts.

J9266 [PEGASPARGASE INJECTION] - $27,070.53

This procedure will also now require Prior Approval and Medical Review.

Analysis will be performed to identify any claims that may have paid prior to the rate being updated in the system.

| TO: AMBULATORY SURGICAL CENTER, CERTIFIED NURSE-MIDWIFE, HOSPITAL, NURSE PRACTITIONER, AND PHYSICIAN PROVIDERS | RE: DELIVERY CODES REMOVED FROM AUDITS 6792 AND 6793 |
|---|---|

Delivery Procedure Codes 59409, 59514, 59612 and 59620 have been removed from audits 6792 (SURGICAL POST OP CARE INCLUDES PREV PD PROC) and 6793 (PROCEDURE IS INCLUDED IN SURGICAL POST-OP PERIOD). Claims analysis will be completed.

**Messages for Remittance Advices dated August 28, 2025 – September 4, 2025**

| TO: CERTIFIED NURSE-MIDWIFE (CNM), NURSE PRACTITIONER, PHYSICIAN, AND PODIATRIST PROVIDERS | RE: PROCEDURE CODES 99234-99236 AND 99238-99239 CHANGES |
|---|---|

Retro effective 8/1/2024, the below procedure codes have been added as covered services to the NURSP and PODI contracts.

PROC DESCRIPTION

99234 HOSP IP/OBS SM DT SF/LOW 45

99235 HOSP IP/OBS SAME DATE MOD 70

99236 HOSP IP/OBS SAME DATE HI 85

For procedure codes 99234-99236 & 99238-99239, POS 51 (INPATIENT PSYCHIATRIC FACILITY) & 61 (COMPREHENSIVE INPATIENT REHABILITATION FACILITY) have been added to the CNMW, MEDSV and NURSP contracts.

Claims analysis will be performed.

**To review more Remittance Advice (RA) Messaging, please visit** Helpful Information for Providers on the AR Department of Human Services (DHS) Website.

# 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**
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### *Supervisor, Outreach Logistics*

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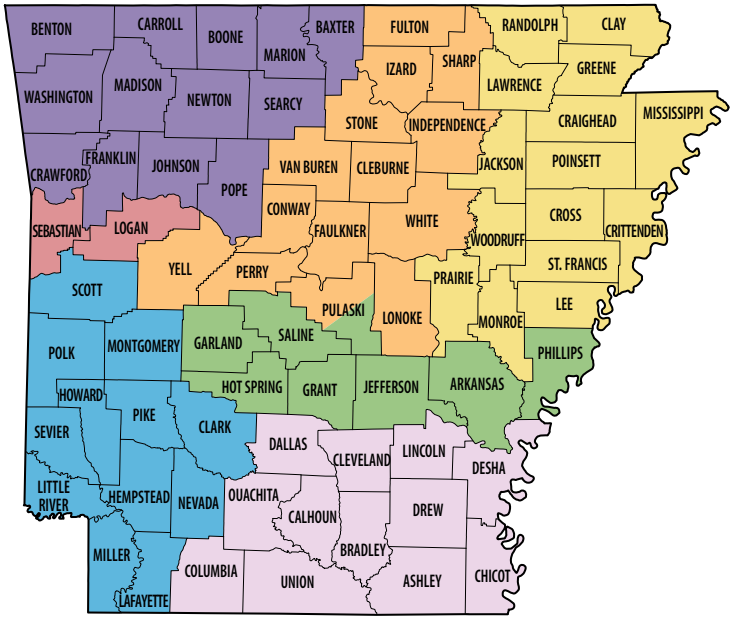


*10/17/2025*

## 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

# IN THIS ISSUE OF ARMedicaid

# ARKANSAS PROVIDER MEDICAID UPDATE

Q2 SFY 2026
(October–December 2025)

- Child Health Services (CHS) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
- Maternal Health Outreach
- Non-Emergency Transportation
- PCMH Activities Tracked for Practice Support – Due 12/31/25

**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