ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

# ARKANSAS PHYSICIAN MEDICAID UPDATE

Q4 SFY 2024
(April–June 2024)

## What's New for Arkansas Medicaid Providers

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

## Ransomware Attack on Change Healthcare

On February 21, 2024, a ransomware attack shut down Change Healthcare operations around the nation. Change Healthcare is not affiliated with Arkansas Medicaid directly, but it operates as a "clearinghouse" for approximately 1000 Arkansas Medicaid providers. A clearinghouse processes payments for providers through multiple billing systems and allows the provider to "batch bill" or submit multiple claims at one time. However, a clearinghouse is *not required* to bill the Arkansas Medicaid system for services rendered. Claims can be submitted directly through the interChange Provider Portal. In fact, interChange, the Arkansas Medicaid billing system, has been working as intended since the attack on February 21, 2024, and Medicaid billing operations have not been directly impacted.

We understand that many providers were directly impacted. We also are aware that it may take Change Healthcare several more weeks to resume normal operations. For more information on the cyberattack and the status of Change Healthcare's work to restore systems, please visit this website: Information on the Change Healthcare Cyber Response – UnitedHealth Group.

To help providers who may have been affected by this large cyberattack, Arkansas Medicaid is providing some informational resources. These resources are both operational and financial.

**Arkansas Provider Billing Portal:** The Arkansas Provider Billing Portal is always available for direct billing, 24 hours a day, seven days a week. The portal can be accessed here: https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx. While the portal does not allow for batch billing, any provider can directly submit a claim for processing and payment. If you need assistance with using the portal, please call 833-764-5599.

**Changing Clearinghouse Vendors:** If you make a business decision to switch clearinghouse vendors, we can assist you with getting the new vendor set up. To do that, please follow these steps:

Update your Trading Partner (clearinghouse) linkage in the portal. This is accessible under Manage Accounts. Additional instructions are available here: https://humanservices.arkansas.gov/wp-content/uploads/MMIS_JobAid_LinkTPID.pdf

When a provider adds a Trading Partner, that gives the Trading Partner access to that provider's 835s (remittance advice data). (* Note that as long as a Trading Partner is active, the Trading Partner can submit claims on behalf of any provider without a linkage, and in fact, Change Healthcare submitted at least one claim to Arkansas Medicaid for an approximately 1760 providers last month.)

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**CMS Guidance:** CMS has issued guidance to Providers, Medicare Advantage Agencies, and other payors which can be found here: https://www.hhs.gov/about/news/2024/03/05/hhs-statement-regarding-the-cyberattack-on-change-healthcare.html. Additionally, Medicare is authorizing some accelerated payments to Medicare providers. To submit these, you must go through the Medicare Administrative Contractor. View additional information from CMS about Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers.

**Payment Assistance:** Optum Financial Services (a fellow United Health Subsidiary) is offering a Temporary Funding Assistance Program for impacted organizations. For more information, visit: https://www.optum.com/en/business/providers/health-systems/payments-lending-solutions/optum-pay/temporary-funding-assistance.html. Medicaid is the payor of last resort by federal regulation. This means we are required to look for any other sources of payment for a claim before we use Medicaid money. Under this policy, Arkansas Medicaid is not currently issuing any advance payments on claims because there are other sources of financial assistance available for providers.

Arkansas Medicaid is working with internal and external partners to ensure we are helping providers who are impacted by this cyberattack. We are holding daily internal status meetings, and representatives from Medicaid and the DHS Office of Information Technology are participating in daily stakeholder meetings regarding the nationwide impacts of this issue. We are enhancing support in our Provider Call Center to ensure providers have assistance available for the next few weeks as these issues are resolved, and in anticipation of enhanced utilization of our Provider Portal billing solution. ■

# Caregiver Depression Screening

If a beneficiary is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be given a behavioral health screen, and the screening will be billed under the minor beneficiary's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source. This policy language is in section II of the physician manual:

**292.741 Behavioral Health Screen 1-1-23**

A physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening will be billed under the minor beneficiary's Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent/legal guardian session will count towards the four (4) counseling screening limit. The physician must have the capacity to treat or refer the parent/guardian for further treatment if the screening results indicate a need, regardless of payor source.

*If the physician office does not provide counseling services, families can be referred to the Mental Health & Addiction Support Line (844-763-0198) for a list of mental health providers.* ■

# Find Substance Abuse or Mental Health Treatment

Did you know that DHS offers these mental health & addiction services to Arkansans who have limited incomes?

- Assessment
- Individual & Group Counseling
- Family Counseling
- Substance Abuse Counseling & Treatment
- Parent & Child Counseling for Children under 4
- Mental Health Medication Needs
- Help During a Mental Health Crisis

When seeking help for mental health or addiction services for yourself or a loved one, the first step is to find a service provider in your area. Below are several directories to assist in locating an appropriate provider. You may also call our **Mental Health & Addiction Support Line** at 1-844-763-0198 to locate providers in your area. After locating a provider in your area, you can call for immediate and confidential help 24 hours a day, seven days a week. Following the initial call, available services will vary from person to person.

If you are facing a **medical emergency**, please dial 911.


988 has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline which is answered 24 hours a day, 365 days a year.

If you would like support to quit using tobacco, please call the **Arkansas Quitline** at 1-800-QUIT-NOW, or visit https://www.bewellarkansas.org/

NAMI Arkansas operates a statewide organization providing and coordinating a network of local support groups providing support, education, and advocacy throughout the state. Please call **NAMI Arkansas** at (800)844-0381 , or visit https://namiarkansas.org/

For people with no insurance needing counseling for mental health issues:
**Therapeutic Counseling Services Provider List** click here

For people who need assistance with DWI/DUI services:
**Drug and Alcohol Safety Education Programs (DASEP)** click here

For those without health insurance needing basic to intensive mental health services.:
**Community Mental Health Centers (CMHC)** list click here

For those without insurance needing drug and alcohol treatment:
**Substance Use Disorder Treatment State Funded directory** click here

**Psychiatric Advance Directive (PAD) Information** click here

For persons interested in developing a legal tool that allows a person with mental illness to state their preferences for treatment prior to a crisis taking place. Once in place the PAD goes into effect when a person is found to lack decision-making capacity. A PAD might outline hospital preferences, who to contact in case of an emergency, and how to best support the person in crisis. This SAMHSA document includes references to additional resources on PADs and crisis planning, a list of terms related to PADs, and some examples of documents which can be used in the development of a PAD. A brief Guide to Psychiatric Advance Directives can be found on pages 41-44. ■

# Behavioral Health Integration and Developmental Screenings

AFMC hosted a webinar on March 1, 2024, for Primary Care Providers featuring Behavioral Health Integration, Independent Assessments (IA) and Referral Process, and Early Intervention Day Treatment (EIDT) Referral Process Changes for Children with the Arkansas Division of Medical Services (DMS).

The webinar recording and slide deck can be found (here). Effective April 1, 2024, Primary Care Providers will complete the following referral and prescription forms for EIDT services for children.

- DMS-642 ER – EIDT Initial Evaluation Referral
- DMS-642 YTP – EIDT Year-Round Treatment Prescription
- DMS-642 STP – EIDT Summer Only Treatment Prescription ■

# Diabetic Supplies Update

As previously communicated, Arkansas Medicaid is updating the billing processes for diabetic supplies including Continuous Glucose Monitors (CGM), which will be changing to a pharmacy claim type submission by both pharmacies and DME providers. Pharmacies will be able to begin billing diabetic supplies via regular NCPDP billing for beneficiaries starting 5/1/2024. DME providers will begin billing in the new portal starting 7/1/2024.

Please review the official notice released March 26, 2024 – Upcoming Continuous Glucose Monitor and Diabetic Supplies Billing Update.

Please visit the pharmacy website http://ar.magellanrx.com for all diabetic supply announcements and criteria. The Magellan Help Desk can be reached Monday through Friday, from 8:00am to 5:00pm, at (800) 424-7895. ■

# Dental and Vision Benefit Plans Crosswalks

Aid Categories currently found in Section I [124.000] of all provider manuals are now known as "Benefit Plans." The Dental and Vision crosswalks were updated 1/18/24 and can be accessed using these links:

Dental-specific Benefit Plans Crosswalk

Vision-specific Benefit Plans Crosswalk ■

# Primary Care Provider (PCP) Dismissal Process

A Primary Care Provider (PCP) can request that a Medicaid Beneficiary be removed from his or her caseload by following the process described in section 173.620 of the Arkansas Medicaid Manual.

**173.620 PCP Transfers by PCP Request 9-15-09**

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

A. Examples of unacceptable arrangements include, but are not limited to, the following.
   1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
   2. The enrollee is abusive to the PCP.
   3. The enrollee does not comply with the PCP's medical instruction.

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

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

Written Notice must be drafted on the PCPs Clinic letterhead and include the following information. If the dismissal letter does not contain this information, processing the dismissal request might be delayed.

- Dated letter (date sent)
- Medicaid beneficiary's name
- Medicaid beneficiary's Medicaid ID
- Medicaid beneficiary's date of birth
- Assigned PCP's name
- Reason for the dismissal
- The letter must state the Medicaid beneficiary has 30 days to enroll with a different PCP and the PCP will continue as the beneficiary's PCP during the 30 days or until the individual transfers to another PCP, whichever comes first.

It is a good practice to mention that the PCP will provide Medicaid Records to the newly assigned PCP with the appropriate medical records release. PCPs can include a copy of the ConnectCare Brochure with their dismissal letter to assist the Medicaid beneficiary with a new PCP assignment.

ConnectCare Brochure, English
ConnectCare Brochure, Spanish

After 30 days have passed from the date of the letter, the PCP should fax the dismissal letter to ConnectCare (501-375-0705) to have the Medicaid beneficiary removed from his or her caseload. The beneficiary will also be locked out, which prevents the beneficiary from being reassigned to the dismissing PCP.

**Note:** Dismissing a Medicaid beneficiary from one PCP's caseload does not prevent the beneficiary from being assigned to another PCP in the same clinic. Dismissals are completed at the PCP level and not the clinic level. ■

## 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.

# Medicaid Provider Enrollment

The Medicaid Provider Enrollment department at Gainwell Technologies completes all Medicaid provider account functions for Medicaid providers including but not limited to: enrolling new providers, licensure updates, address changes, revalidations, group affiliations, and adding a service county to your PCP caseload.

Section 141.000 Provider Enrollment requires each provider to notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

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

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

C. Authorization for Electronic Funds Transfer (Automatic Deposit)

D. Change in practice or specialty

E. Retirement or death of provider

F. Name Change Form

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

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

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

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

The Provider Enrollment department has an informational web page which contains video instructions on completing a provider application, quick guides on how to complete an enrollment application, application tips, FAQs, and printable enrollment related forms. This web page is a great resource to use for many of the processes performed by Provider Enrollment. https://humanservices.arkansas.gov/divisions-shared-services/medical-services/provider-enrollment/

It's best to upload forms to Provider Enrollment using the MMIS provider portal. When uploading to the portal, uploads are logged with a tracking number which allows you to track the status of your uploaded request. Please note the tracking number for future needs. When you call Provider Enrollment for assistance, you will be given a tracking number for your issue. Please note the tracking number for future needs. Doing so makes it easier for the Provider Enrollment team to locate your issue.

If you have any questions or issues with your Provider Enrollment needs, please contact Provider Enrollment directly at 800-457-4454. ■

# PCMH Updates

***Care plans*** – Providers no longer have to wait until the end of the PCMH performance year to upload care plans for their High Priority Beneficiaries (HPB). The AR Division of Medical Services (DMS) will turn on a feature in the QCI portal after HPB selection, allowing providers to upload care plans throughout the year.

***Activity Attestation*** – Providers no longer have to wait to attest to the activities when they are due. DMS has activated a feature in the QCI portal to allow providers to attest to their activities throughout the PCMH performance year.

***Act 513*** – For practices that have completed training or are on track to achieve fidelity (certification) in a program approved by DHS (Healthy Steps) to be an evidence-based pediatric practice transformation model defined in A.C.A. § 20-77-150 will receive an additional $3.44 per month added to their PBPM for their beneficiaries ages 0-48 months. ■

# Messages for AR Medicaid Providers

**Remittance Advice dated March 21, 2024 – March 27, 2024**

**TO: ALL PROVIDERS** **RE: PAYMENT ERROR RATE MANAGEMENT (PERM) REQUESTS**

Payment Error Rate Management (PERM) is a program designed for CMS to measure improper payments in the Medicaid and CHIP programs. A random selection of claims during July 1, 2023 – June 30, 2024, will require additional information from AR Medicaid providers. If you receive a request for medical records, please submit the requested information by the deadline provided in the letter. Failure to comply with the request can result in recoupment and/or penalties. Providers can expect letters to be distributed as early as March 2024.

**Remittance Advice dated March 7, 2024 – March 14, 2024**

**TO: ALL PROVIDERS** **RE: RANSOMWARE ATTACK ON CHANGE HEALTHCARE**

On February 21, 2024, a ransomware attack shut down Change Healthcare operations around the nation. DHS has posted a response to this on the Helpful Information for Providers webpage. View this message on the DHS website at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/ in the "What's new for Arkansas Medicaid Providers" section of the webpage.

**TO: ALL PROVIDERS** **RE: PROVIDER GUIDANCE: COORDINATION OF BENEFITS**

"Medicaid beneficiaries are required to use third party sources of coverage that are available to them at no cost. By seeing an out-of-network provider, the Medicaid beneficiary was not using his or her available health care resources. Consistent with the general principle that Medicaid is the payer of last resort, Medicaid will not reimburse the provider or the beneficiary for any balance not paid by the commercial plan" (CMS, p.54, 2020).

If you provide services to a Medicaid eligible member but the services are denied by the member's primary insurance, you can use either a Certificate of Benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment) as proof the primary insurance was billed. Keep this in the client file for auditing purposes. The Certificate of Benefits or Denial EOB is good for one year.

Please note that it is the provider's responsibility to follow the billing policies of the liable third-party payer. Procedural denials from the liable third-party payer should be resolved prior to billing Medicaid. Failure to resolve procedural denials prior to billing Medicaid may result in delayed payments or denied claims. Additionally, the Medicaid filing deadline is not delayed while providers chase payment from potentially liable commercial third-party plans.

To show how this should be billed so the claim will bypass the TPL editing, the following example is provided.

The provider receives a denial letter from the insurance company (EOB with no payment to provider) dated 01/01/2019. The provider would say yes, primary insurance was billed using the denial date of 01/01/2019 and $0.00 payment amount in this example. Be sure to include the Claim Filing Indicator.

Reference: Centers for Medicare and Medicaid Services (CMS) (2020); Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid 2020; Retrieved 2/1/2024 URL: https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf

**Remittance Advice dated February 22, 2024 – February 29, 2024**

**TO: ALL PROVIDERS**

**RE: EDIT 3383 (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS) RETROSPECTIVE REVIEW RECOUPMENT - EOMB**

DHS will begin the recoupment of certain previously paid Medicare Advantage Crossover claims that were included in the Edit 3383 Retrospective Review. The impacted providers who did not submit the EOMB (Explanation of Medicare Benefits) as requested will have their claims recouped. The claims recoupment will begin on or after March 8, 2024.

The provider may rebill and submit the EOMB for all claims within the filing deadline.

**TO: PHYSICIAN, HOSPITAL, INDEPENDENT RADIOLOGY, AND NURSE PRACTITIONER PROVIDERS**

**RE: RATES FOR 77520, 77522 AND 77523**

Effective 2/1/2023, the following procedure code rates have been added to the system:

| RADIOLOGY Contract | OUTPATIENT Contract |
|---|---|
| 77520 - $924.22 | 77520 - $924.22 |
| 77520 TC - 369.73 | 77522 - $924.22 |
| 77522 - $924.22 | 77523 - $1,061.50 |
| 77522 TC - $369.73 | |
| 77523 - $1,061.50 | |
| 77523 TC - $424.60 | |

**Messages for Remittance Advices dated January 4, 2024 – January 11, 2024**

**TO: PHARMACY PROVIDERS**

**RE: MAGELLAN PHARMACY POINT OF SALE SYSTEM WILL BE DOWN**

Magellan will be performing maintenance to the pharmacy point of sale system beginning Saturday, January 13 at 10:00 PM CT and lasting approximately 90 minutes. The pharmacy point of sale claims system will be down during this timeframe.

**TO: DENTAL AND ORAL SURGEON PROVIDERS**

**RE: ISSUE WITH AUDITS USING TIME UNIT 'Y' AND TIME SPAN GREATER THAN (>)**

One or more of your claims have been identified for a recoupment as claims were paid in error. You do not need to take any action. Your claims will be reprocessed after January 17, 2024.

**TO: AREA HEALTH EDUCATION CENTER (AHEC), ARKANSAS DEPARTMENT OF HEALTH (ADH), HOSPITAL, NURSE PRACTITIONER, AND PHYSICIAN PROVIDERS**

**RE: PROCEDURE CODE 96381 COVERED AS OF 10/6/2023**

Arkansas Department of Human Services has updated the system to add coverage for procedure code 96381 (Admin RSV monoc antibody intramuscular inj) under the Certified Nurse Midwife, Medical Services, Nurse Practitioner, and Outpatient contracts. These changes are retroactive to 10/6/2023. Claims analysis will be completed.

**TO: ALL PROVIDERS**

**RE: CTS A, C AND I ADDED TO EDITS 528 AND 817**

Arkansas Department of Human Services has updated the system to include claim types A (Inpatient crossover), C (Outpatient crossover) and I (Inpatient) to edits 528 (Detail First Date of Service/To Date of Service Billed in Error) and 817 (Detail To Date of Service Not Within Header Range). This is effective immediately. When submitting claims, ensure that the dates of service on claim detail are within the header dates of services on the claim.

# What's New for Arkansas Medicaid Providers

Official notices posted from January 1, 2024 – March 31, 2024. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

| Title | Posted Date | Category |
|---|---|---|
| Coverage for Procedure T1015 Medication Assistance Treatment (MAT) Services (X2 & X4 Modifiers) | 3/28/2024 | Procedure Codes |
| Upcoming Continuous Glucose Monitor and Diabetic Supplies Update | 3/24/2024 | Billing Instruction |
| 2024 Annual and Quarter 1 Healthcare Common Procedure Coding System Level II (HCPCS) Code, Current Procedural Terminology (CPT), and ASC Code Conversion | 3/19/2024 | Procedural Codes |
| Coverage for Procedure 87635 | 3/1/2024 | Procedure Codes |
| REVISED – Long-Acting Reversible Contraceptive (LARC) Covered During Inpatient Stay | 2/2/2024 | Procedure Codes |
| New Coverage for Vaccines – Effective 10/1/2023 | 2/9/2024 | Procedure Codes |
| Billing for Triage, Treat, and Transport (ET3) | 1/30/2024 | Procedure Codes |
| EPSDT Billing Updates for Procedure Code 96110 | 1/19/2024 | Procedure Codes |
| Long-Acting Reversible Contraceptive (LARC) Covered During Inpatient Stay | 1/3/2024 | Procedure Codes |

**TO:** **Health Care Providers – All Providers**
**DATE:** **March 26, 2024**
**SUBJECT:** **Upcoming Continuous Glucose Monitor and Diabetic Supplies Billing Update**

**I. General Information**

As previously communicated, Arkansas Medicaid is updating the billing processes for diabetic supplies including Continuous Glucose Monitors (CGM), which will be changing to a pharmacy claim type submission by both pharmacies and DME providers. Pharmacies will be able to begin billing diabetic supplies via regular NCPDP billing for beneficiaries starting 5/1/2024. DME providers will begin billing in the new portal starting 7/1/2024.

- DME providers will have an extra 60 days from the previous communicated 5/1 start date to transition to the new portal beginning 7/1/2024.
- The official portal enrollment and training details will be announced on a separate Official Notice.
- Please note that the upcoming billing process change will not apply to those members with Medicare Part B benefits, or for those members needing traditional insulin pumps with tubing and canula type supplies, as the current Durable Medical Equipment (DME) benefit and billing rules will remain unchanged.
- Existing DME prior authorizations for CGM and other diabetic supplies will be extended until 6/30/2024, unless hitting the 6-month limitation. Those prior authorizations at the 6-month limit or a new request may be authorized until 6/30.

**I. Location for Diabetic Supplies Information**

Please visit the pharmacy website http://ar.magellanrx.com for all diabetic supply announcements and criteria. The Magellan Help Desk can be reached Monday through Friday, from 8:00am to 5:00pm, at (800) 424-7895.

**TO:** **Health Care Providers – Hospital, Independent Laboratory, Nurse Practitioner, and Physician**
**DATE:** **March 1, 2024**
**SUBJECT:** **Coverage for Procedure 87635**

## I. General Information

Arkansas Department of Human Services added coverage for procedure code 87635 effective 2/1/2024.

Procedure code 87635 (SARS-COV-2 COVID-19 AMP PRB) and U0002 (COVID-19 LAB TEST NON-CDC) will not be reimbursed for the same date of service and same member.

## II. Procedure Code

The following procedure code is effective 2/1/2024 under the Laboratory (LAB), Medical Services (MEDSV), Nurse Practitioner (NURSP) and Outpatient (OUTPA) Contracts:

| Proc Code | Description | Contract | Diag Group |
|---|---|---|---|
| 87635 | SARS-COV-2 COVID-19 AMP PRB | LAB, MEDSV, NURSP & OUTPA | 2024 |

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**TO:** **Health Care Providers – Certified Nurse-Midwife (CNM), Hospital, Nurse Practitioner, and Physician**
**DATE:** **February 29, 2024**
**SUBJECT:** **REVISED – Long-Acting Reversible Contraceptive (LARC) Covered During Inpatient Stay**

## I. General Information

Arkansas Department of Human Services has added coverage for the below mentioned LARC procedure/modifier combinations to be separately reimbursed while administered during an inpatient stay immediately post-partum, effective 1/1/2024. Billing instructions have been provided in the Hospital Provider Manual under section 216.000 Family Planning.

## II. Billing Guidelines

- The hospital should continue to bill the inpatient stay on Inpatient claim (CMS-1450, formerly UB-04).
- If the hospital provides the LARC device, the hospital is to bill the LARC device on an outpatient claim (CMS-1450, formerly UB-04), even though the dates fall within inpatient stay. Ensure the applicable NDC code is submitted on claim.
- Physician charges can be billed for insertion/removal on a professional claim (CMS-1500), in addition to their delivery charges. The physician can also charge for the LARC device, if provided by the Physician. The 340-B rules and modifiers to the LARC procedure code combinations apply, when applicable.

## III. Procedure Codes

The following procedure codes should be billed for Hospital Services under the OUTPA (Outpatient) Contract effective 1/1/2024:

| Proc Code | Mod | Description | Gender | Age | Diag |
|---|---|---|---|---|---|
| J7296 | FP U1 | LEVONO-IUD CONTRACEP SYS (KYLEENA) 19.5mg, supplied by hospital during inpt stay | F | 10+ yrs | 917 |
| J7297 | FP U1 | LEVONO-IUD CONTRACEP SYS (LILETTA), 52mg, supplied by hospital during inpt stay | F | 12-65 yrs | 917 or 636 |
| J7298 | FP U1 | LEVONO-IUD CONTRACEP SYS (MIRENA), 52mg, supplied by hospital during inpt stay | F | 12-65 yrs | 917 or 636 |

| Proc Code | Mod | Description | Gender | Age | Diag |
|---|---|---|---|---|---|
| J7300 | FP U1 | INTRAUTERINE COPPER CONTRACEPTIVE, supplied by hospital during inpt stay | F | 12-65 yrs | 917 |
| J7301 | FP U1 | LEVONO-IUD CONTRACEP SYS (SKYLA) 13.5mg, supplied by hospital during inpt stay | F | 10+ yrs | 917 |
| J7307 | FP U1 | ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES, supplied by hospital during inpt stay | F | | 917 |

The following procedure codes should be billed for Professional Services under the FAMPL (Family Planning) Contract effective 1/1/2024:

| Proc Code | Mod | Description | Gender | Age |
|---|---|---|---|---|
| 11976 | FP U1 | REMOVAL OF IMPLANTABLE CONTRACEPTIVE CAPSULES – during inpt stay | F | |
| 11981 | FP U1 | INSERTION OF DRUG DELIVERY IMPLANT INTO TISSUE - during inpatient stay | F | |
| 58300 | FP U1 | INSERTION OF IUD FOR PREGNANCY PREVENTION - during inpatient stay | F | |
| 58301 | FP U1 | REMOVAL OF IUD - during inpatient stay | F | |
| J7296 | FP U1 | LEVONO-IUD CONTRACEP SYS (KYLEENA) 19.5mg, supplied by provider during inpt stay | F | 10+ yrs |
| J7297 | FP U1 | LEVONO-IUD CONTRACEP SYS (LILETTA), 52mg, supplied by provider during inpt stay | F | 12-65 yrs |
| J7298 | FP U1 | LEVON-IUD CONTRACEP SYS (MIRENA), 52mg, supplied by provider during inpt stay | F | 12-65 yrs |
| J7300 | FP U1 | INTRAUTERINE COPPER CONTRACEPTIVE - supplied by provider during inpt stay | F | 12-65 yrs |
| J7301 | FP U1 | LEVONO-IUD CONTRACEP SYS (SKYLA) 13.5mg, supplied by provider during inpt stay | F | 10+ yrs |
| J7307 | FP U1 | ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES, supplied by provider during inpt stay | F | |

**TO:** **Health Care Providers – Certified Nurse-Midwife (CNM), Hospital, Nurse Practitioner, and Physician**
**DATE:** **January 19, 2024**
**SUBJECT:** **EPSDT Billing Updates for Procedure Code 96110**

## I. General Information

Arkansas Department of Human Services has made the below changes for EPSDT Developmental Screening, effective 1/1/2024. Billing guidelines have been provided in the EPSDT Provider Manual under sections:

- 215.310 Infancy (Ages 1-9 months) bullet J.
- 215.320 Early Childhood (Ages 12 months-4 years) bullet K.

## II. Billing Guidelines

- Under the Medical Services (MEDSV) and Nurse Practitioners (NURSP) contract, Procedure code 96110 (DEVELOPMENTAL SCREEN W/ SCORE) is only covered for members 0-48 months of age and must be billed with any of the following procedure codes on the same date of service for the same member:

| Proc Code | Mod | Description |
|---|---|---|
| 99381 | EP H9 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (FOSTER CARE) - UNDER 1 YEARS OLD |
| 99381 | EP U1 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (NEW PATIENT) - UNDER 1 YEARS OLD |
| 99382 | EP H9 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (FOSTER CARE) - AGES 1-4 YRS |
| 99382 | EP U1 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (NEW PATIENT) - AGES 1-4 YRS |
| 99391 | EP H9 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (FOSTER CARE) - UNDER 1 YEARS OLD |
| 99391 | EP U2 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (ESTABLISHED PATIENT) - UNDER 1 YEARS OLD |
| 99392 | EP H9 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (FOSTER CARE) - AGES 1-4 YRS |
| 99392 | EP U2 | EPSDT PERIODIC COMPLETE MEDICAL SCREEN (ESTABLISHED PATIENT) - AGES 1-4 YRS |

- Procedure code 96110 is no longer covered under the Certified Nurse Midwives (CNMW) Contract.
- Limitation audits for procedure code 96110:
  - Once for members ages 0-12 months.
  - Twice for members ages 13-48 months, with at least a 12-month period between the first and second visit.

If you have questions regarding this notice, please contact the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211. If you need this material in an alternative format, such as large print, please contact the Office of Rules Promulgation at (501) 320-6428. Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making, and remittance advice (RA) messages are available for download from the Division of Medical Services website.

Thank you for your participation in the Arkansas Medicaid Program. ■

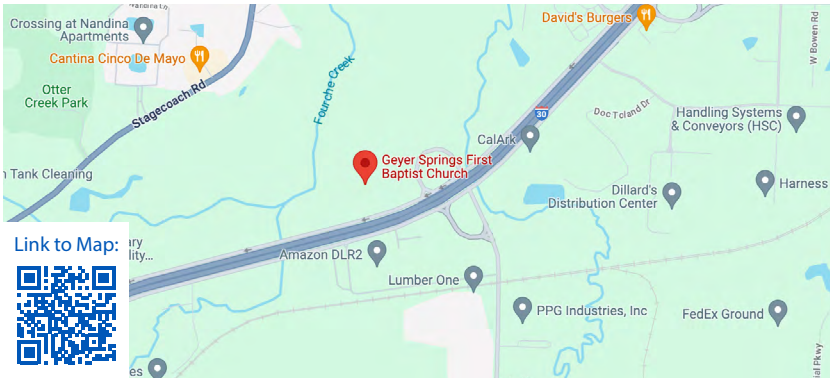
REGISTER NOW!

# Register today for the AFMC MMIS Annual Billing Conference

## May 9, 2024!

The MMIS Outreach Team has big news! We will not be hosting five regional Annual Billing Workshops this fall. Instead, we will now host one centralized Annual Billing Conference for all Arkansas Medicaid providers. This event will be held at the Geyer Springs First Baptist Church in Little Rock, AR.

See map below with address and directions:




**Geyer Springs First Baptist Church**

**12400 I-30**

Little Rock, AR

## The conference will be from 9 a.m. - 3:30 p.m.

*We will break for lunch from 12:00 – 1:30. Please note that lunch is not provided.*
*Please limit your registration to five people per organization.*

Registered attendees will receive a link to the conference presentations via email approximately two days prior to the conference. If you would like printed copies of the presentations, please print them at home as copies will not be provided on-site.

**SCAN HERE TO REGISTER!**

OR VISIT **AFMC.ORG/ABC**

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Healthy **People.** Healthy **Businesses.**
Healthy **Communities.**

# Provider Relations Outreach Specialists Information Sheet

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

## AFMC OUTREACH SPECIALISTS

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

### *Manager*

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

### *Supervisor, Provider Relations*

**Kellie Cornelius** ..... **501-804-2501**
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### *Outreach Specialists*

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**Jackie Clarkson**.....**501-553-7665**
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**Carla Hestir**.....**501-804-2901**
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**Connie Riley**.....**501-545-7873**
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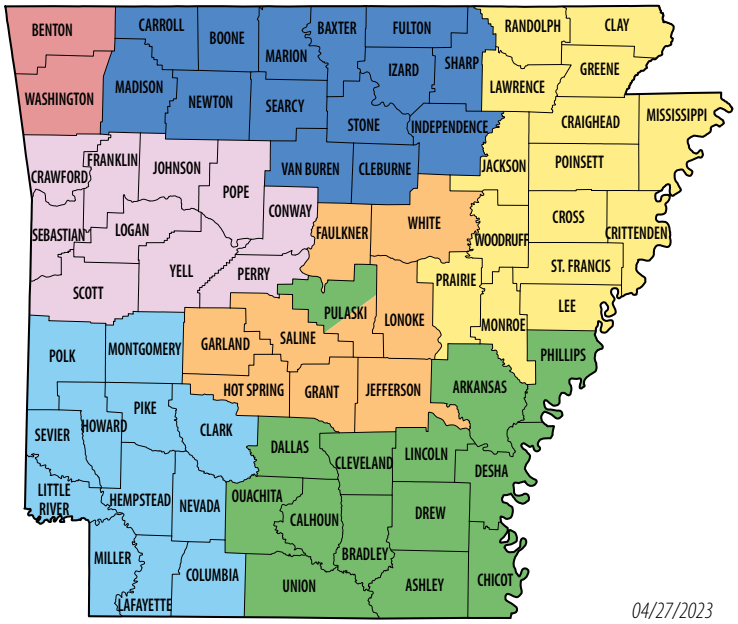
### *Supervisor, Outreach Logistics*

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




*04/27/2023*

## GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

### *Gainwell Provider Assistance Center*

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

### *Gainwell Technologies Services*

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

## ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

### ARKIDS FIRST/MEDICAID MEDICAL ASSISTANCE

**https://humanservices.arkansas.gov**
- ARKids First Enrollment Information ..... **888-474-8275**

### CONNECTCARE

- Toll free ..... **800-275-1131**

### MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

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

### VOICE RESPONSE SYSTEM

- Toll free ..... **800-805-1512**

### AFMC SERVICE CENTER (CLIENTS)

- Toll free ..... **888-987-1200**

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

### MAGELLAN MEDICAID ADMINISTRATION

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

### THIRD PARTY LIABILITY

- Local..... **501-537-1070**
- Fax ..... **501-682-1644**

DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

# IN THIS ISSUE OF ARMedicaid

## ARKANSAS PHYSICIAN MEDICAID UPDATE

Q4 SFY 2024
(April–June 2024)

- Caregiver Depression Screening
- Dental and Vision Benefit Plan Crosswalks
- Diabetic Supplies Update
- Find Substance Abuse or Mental Health Treatment
- Messages for AR Medicaid Providers
- PCP Beneficiary Dismissal Process
- Ransomware Attack on Change Healthcare

**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