ARMedicaid
ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS PROVIDER MEDICAID UPDATE

Q4 SFY 2025
(April–June 2025)

What's New for Arkansas Medicaid Providers

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

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Upcoming Changes for Preferred Blood Glucose Meters

Effective May 1, 2025, Abbott Freestyle brand glucose meters and supplies will be added as preferred options for Arkansas Medicaid. (Note: True Metrix glucose meters and strips will remain as additional preferred options.)

The following Abbott blood glucose meters will be added as preferred products:

- FreeStyle Freedom Lite
- FreeStyle Lite
- FreeStyle Precision Neo
- Precision Xtra

The following Abbott blood glucose test strips will be added as preferred products:

- FreeStyle Insulinx
- FreeStyle Lite
- FreeStyle
- Precision Xtra
- FreeStyle Precision Neo

Effective May 1, 2025, the following will be designated as non-preferred options for Arkansas Medicaid:

- OneTouch Verio Reflect and corresponding test strips
- OneTouch Ultra2 and corresponding test strips
- OneTouch Verio Flex and corresponding test strips

Beneficiaries currently using a OneTouch product will need a new prescription for either a FreeStyle or True Metrix product beginning on May 1, 2025.

For any questions, contact the Prime Therapeutics Help Desk at (800) 424-7895. ■

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Health Care Programs

The Health Care (AR Medicaid) program helps eligible individuals pay some of their medical bills. Eligibility is determined based on income, resources, Arkansas residency, and other requirements. Covered services also vary among Health Care categories. The program offers coverage for individuals of all ages, with special categories for the blind, disabled, pregnant, and those who need long-term services in a nursing facility or in community-based settings.

The AR Medicaid program reimburses health care providers for covered medical services provided to eligible individuals. Categories are summarized below.

Aged, Blind, and Disabled

Individuals aged 65 and older who meet income, resources, and other requirements are eligible for full coverage. Similarly, individuals who are determined blind or disabled based on Social Security Administration criteria and who meet income, resources, and other requirements are eligible for full coverage.

Medicare Savings Program

Eligible individuals receive limited coverage to supplement Medicare costs. Coverage varies based on income, ranging from payment of the Medicare premiums, deductibles, and co-insurance for low-income individuals to paying only a portion of the Medicare Part B premium for individuals with higher incomes.

Long-Term Services and Supports | More Information

- **Nursing Facility (Long Term Care)**—This program provides coverage for nursing home residents if the care in the facility is medically necessary and they meet income, resources, and other requirements.
- **Living Choices (Assisted Living)**—This program provides coverage in an assisted living facility for individuals aged 65 or older or individuals aged 21 or older who are blind or have a physical disability and meet the income, resources, and other requirements. Services are provided to eligible individuals to allow them to maintain their independence and dignity while receiving a high level of care and support.
- **ARChoices**—This program provides coverage for home and community-based services for adults aged 21–64 with a physical disability OR age 65 and older who need help with an activity of daily living and meet nursing facility functional needs criteria, income, resources, and other requirements.
- **Community and Employment Supports**—This program serves individuals of any age who are determined to be developmentally or intellectually disabled and who would be eligible for coverage if they were in a nursing facility but choose to remain at home.
- **Program of All-Inclusive Care for the Elderly (PACE)**—This program provides comprehensive health and social services to coordinate primary, preventive, acute, and long-term services and support for individuals 55 years old or older who need nursing facility care. The individual must also meet income, resources, and other requirements.
- **Workers with Disabilities**—This program provides full coverage to disabled individuals aged 16 to 65 who are working. Individuals with lower income pay the normal Health Care co-pays. Individuals with a higher income pay higher co-pays.

Children and Family

- ARHOME—This program is for people ages 19–64 who meet income and other eligibility requirements. Coverage is provided either through an individual qualified health insurance plan or traditional fee-for-service Medicaid.
- ARKids First—This program is for children and teens. It is divided into two categories. ARKids A provides a full range of health care services to children under age 19 with family income under 142% of the Federal Poverty Level. ARKids B provides coverage to otherwise uninsured children under age 19 with family income equal to or over 142% but under 211% of the Federal Poverty Level. ARKids B provides a more limited range of services with limited co-pays for some services.
- **Newborn**—This program provides full coverage to children up to age 1 whose mothers were eligible for Health Care provided by the State at the time of the baby's birth. Children approved in the Newborn category are guaranteed coverage for the first year of life regardless of income changes that may occur during that first year of life.
- TEFRA—This is a home and community-based program for individuals aged 18 or younger with disabilities that meet the medical necessity requirement for institutional placement in a hospital, a skilled nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) or are at risk for future institutional placement. Individuals must also meet the income, resources, and other eligibility requirements.
- **Autism Waiver**—This program is for individuals aged 18 months through seven (7) years who have a diagnosis of autism. In addition to the diagnosis of autism, the waiver participant must meet the income, resource, and other eligibility requirements.
- **Parent or Other Caretaker Relative**—This program provides full coverage to adults who have related minor children in the home for whom they exercise care and responsibility and meet income and other requirements.
- **Full Pregnant Woman**—This program provides full coverage for women aged 19 and older who are pregnant at the time of application and meet income and other eligibility requirements.
- **Unborn Pregnant Woman**—This program is for non-citizen pregnant women who meet income requirements but do not meet citizenship requirements. Limited coverage includes prenatal, delivery, postpartum, and conditions that may complicate pregnancy. Coverage continues through the pregnancy and until the end of the month of the 60th day postpartum.
- **Emergency Health Care Services for Aliens**—This program is for individuals who are considered nonqualified aliens living in the U.S. or qualified aliens living in the U.S. for less than five (5) years. Coverage is available for fixed periods of time necessary for acute onset emergency services if the individual meets the financial, categorical, and other eligibility requirements.

The Health Care Eligibility – Quick Reference Guide provides the AR Medicaid program description, income limit, income disregards, resources limit, resources that are counted and excluded, and other important information. The guide was updated January 2025 and can be accessed at Health Care Programs–Arkansas Department of Human Services. ■

AR Medicaid Provider Manuals and Notifications

Remittance Advice

Providers are notified regarding the status of their claims, including payments, denials, and adjustments. AR Medicaid distributes weekly remittance advice (RA) reports to providers, summarizing the status of claims processed during the previous weekend cycle. Additional messaging includes but is not limited to, immediate changes to billing and updates for coding, billing, and claims submission requirements.

Official Notice

AR Medicaid official notices are announcements from the Arkansas Department of Human Services that contain important information for providers, members, and the public regarding changes to Medicaid policies, procedures, and programs.

Fee Schedule

AR Medicaid provides fee schedules that reflect only procedure codes that are currently payable. Procedure codes and fee schedule amounts do not guarantee payment, coverage, or the amount allowed.

Procedure Code Tables

Procedure code tables do not address, and are not meant to provide, all the various coverage limitations routinely applied by AR Medicaid before final payment is determined (including but not limited to client and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age or gender restrictions, prior authorization, diagnosis requirements, co-payments, or coinsurance where applicable).

Although every effort is made to ensure the accuracy of information, discrepancies may still occur. Procedure code tables may be changed or updated at any time to correct such discrepancies.

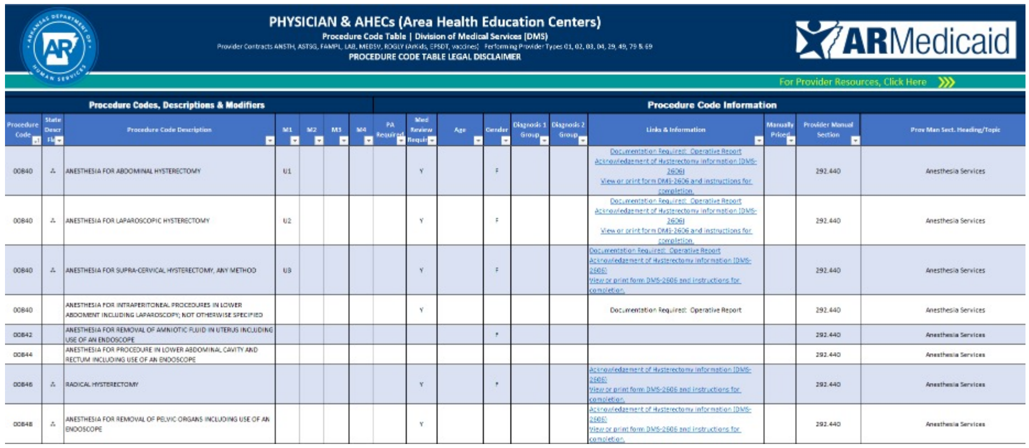
The procedure codes listed do not guarantee that a claim will be accepted or that payment, coverage, or an allowed amount will be provided.

Procedure codes reflected in procedure code tables are in effect as of the date of the document. Procedure code tables are intended to reflect only procedure codes that are currently payable as of the date of the table version.

The allowed reimbursement rates related to the procedure codes submitted on a claim depend on the claim's date of service because AR Medicaid's authorized procedure codes and related reimbursement rates are date-of-service effective.

Providers are responsible for verification and compliance with all requirements for filing claims correctly for allowed reimbursement.

Example screenshot:



PHYSICIAN & AHECs (Area Health Education Centers)
Procedure Code Table | Division of Medical Services (DMS)
Provider Contracts ANSTH, ASTSG, FAMPL, LAB, MEDSV, ROGLY (ArKids, EPSDT, vaccines) Performing Provider Types 01, 02, 03, 04, 29, 49, 79 & 69
PROCEDURE CODE TABLE LEGAL DISCLAIMER

ARMedicaid

For Provider Resources, Click Here

Procedure Codes, Descriptions & Modifiers							Procedure Code Information									
Procedure Code	State Descr Flag	Procedure Code Description	M1	M2	M3	M4	PA Required	Med Review Required	Age	Gender	Diagnosis 1 Group	Diagnosis 2 Group	Links & Information	Manually Priced	Provider Manual Section	Prov Man Sect. Heading/Topic
00840	∴	ANESTHESIA FOR ABDOMINAL HYSTERECTOMY	U1					Y		F			Documentation Required: Operative Report Acknowledgement of Hysterectomy information (DMS-2606) View or print form DMS-2606 and instructions for completion.		292.440	Anesthesia Services
00840	∴	ANESTHESIA FOR LAPAROSCOPIC HYSTERECTOMY	U2					Y		F			Documentation Required: Operative Report Acknowledgement of Hysterectomy information (DMS-2606) View or print form DMS-2606 and instructions for completion.		292.440	Anesthesia Services
00840	∴	ANESTHESIA FOR SUPRA-CERVICAL HYSTERECTOMY, ANY METHOD	U3					Y		F			Documentation Required: Operative Report Acknowledgement of Hysterectomy information (DMS-2606) View or print form DMS-2606 and instructions for completion.		292.440	Anesthesia Services
00840		ANESTHESIA FOR INTRAPERITONEAL PROCEDURES IN LOWER ABDOMENT INCLUDING LAPAROSCOPY; NOT OTHERWISE SPECIFIED						Y					Documentation Required: Operative Report		292.440	Anesthesia Services
00842		ANESTHESIA FOR REMOVAL OF AMNIOTIC FLUID IN UTERUS INCLUDING USE OF AN ENDOSCOPE								F					292.440	Anesthesia Services
00844		ANESTHESIA FOR PROCEDURE IN LOWER ABDOMINAL CAVITY AND RECTUM INCLUDING USE OF AN ENDOSCOPE													292.440	Anesthesia Services
00846	∴	RADICAL HYSTERECTOMY						Y		F			Acknowledgement of Hysterectomy information (DMS-2606) View or print form DMS-2606 and instructions for completion.		292.440	Anesthesia Services
00848	∴	ANESTHESIA FOR REMOVAL OF PELVIC ORGANS INCLUDING USE OF AN ENDOSCOPE						Y					Acknowledgement of Hysterectomy information (DMS-2606) View or print form DMS-2606 and instructions for completion.		292.440	Anesthesia Services

RA messaging, official notices, fee schedules, and procedure code tables can be found on the same page as the AR MCD policy manual for the individual provider type. All messaging is specific to the provider type you choose to review.

Provider manual sections:

The Arkansas Medicaid provider manual is organized into five main sections:

Section I: General Medicaid Policy

- This section provides general information about the AR MCD program, including beneficiary eligibility and provider roles and responsibilities.

Section II: Program Policy

- This section outlines specific program policies and program-specific billing information for a specific provider type, including special billing procedures.

Section III: Billing Information

- This section explains the general procedures for billing in the AR MCD program, covering topics like electronic options, timely filing of claims, and claim inquiries.

Section IV: Glossary

- This section provides definitions of terms used in the Medicaid program and provider manuals.

Section V: Forms and Contacts

- This section contains forms and contact information for various inquiries and issues.

AR Medicaid provider manuals and other provider notifications can be accessed at https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/.

Example screenshots:

Hospital

Drop Down

The following documents are available for this provider type. See also All Providers.

Provider Manual

- Section I – General Medicaid Policy
  - Section I
  - Section I Update Log
  - Other Policy-Related Notifications for All Provider Types
- Section II – Program Policy
  - Section II
  - Section II Update Log
  - Other Policy-Related Notifications for this Provider Type
- Section III – Billing Information
  - Section III
  - Section III Update Log
- Section IV – Glossary
  - Section IV
  - Section IV Update Log
- Section V – Forms and Contacts
  - Section V
  - Section V Update Log

To see the full history of Notices of Rulemaking and Official Notices for this provider type, please download from the manual "Other Policy-Related Notifications for this Provider Type" using the link above. Additional Notices issued for all provider types can be found using the "Other Policy-Related Notifications for All Provider Types" link above.

RA Messages

Date	Subject
3/27/25-4/10/25	Coverage for Procedure Code 58674 – LAPS ABLTJ UTERINE FIBROIDS
3/20/25-4/3/25	Diagnosis Group 700 Updated
3/13/25-4/10/25	MUMP Inpatient
12/5/24-12/19/24	Updates to Diagnosis Code Group 2014
12/5/24-12/19/24	Updates to Diagnosis Group 2031 'DX CODES EXEMPT FROM POA INDICATOR'
9/19/24-10/3/24	IMMEDIATE CHANGES: Changes to Physician Assistant Independent Billing – State Plan Amendment 24-0003
8/15/24-8/29/24	Rates for 0239U and 81455
5/23/24-6/6/24	Edit 3383 Retrospective EOMB Review
5/9/24-5/23/24	Correction to Group 5080 with Missing HCPCS Procedure Codes
3/28/24-4/11/24	Transplant Billing
2/22/24-3/7/24	Rates for 77520, 77522 and 77523

Fee Schedules

Procedure Code Tables

Physician

Drop Down

The following documents are available for this provider type. See also All Providers.

Provider Manual

- Section I – General Medicaid Policy
  - Section I
  - Section I Update Log
  - Other Policy-Related Notifications for All Provider Types
- Section II – Program Policy
  - Section II
  - Section II Update Log
  - Other Policy-Related Notifications for this Provider Type
- Section III – Billing Information
  - Section III
  - Section III Update Log
- Section IV – Glossary
  - Section IV
  - Section IV Update Log
- Section V – Forms and Contacts
  - Section V
  - Section V Update Log

To see the full history of Notices of Rulemaking and Official Notices for this provider type, please download from the manual "Other Policy-Related Notifications for this Provider Type" using the link above. Additional Notices issued for all provider types can be found using the "Other Policy-Related Notifications for All Provider Types" link above.

RA Messages

Date	Subject
3/27/25-4/10/25	Coverage for Procedure Code 58674 – LAPS ABLTJ UTERINE FIBROIDS
3/20/25-4/3/25	ARKids Hearing/Vision Screenings
3/20/25-4/3/25	Diagnosis Group 700 Updated
12/12/24-12/26/24	POS 31 Coverage Added to Procedure 99418
12/5/24-12/19/24	Coverage Update for Procedure 58575
9/19/24-10/3/24	IMMEDIATE CHANGES: Changes to Physician Assistant Independent Billing – State Plan Amendment 24-0003
7/15/24-7/29/24	Rates for 0239U and 81455
7/18/24-8/1/24	Place of Service (POS) and Medical Review Corrections for Procedures 37241, 37242, 37244, and 38571
5/23/24-6/6/24	Edit 3383 Retrospective EOMB Review
5/2/24-5/16/24	Counseling Services Parent Screenings
4/25/24-5/9/24	Pharmacy Billing of CGM and Diabetic Supplies Delayed
4/11/24-4/25/24	PA Required on A9513
3/28/24-4/11/24	Transplant Billing
2/22/24-3/7/24	Rates for 77520, 77522 and 77523

Fee Schedules

Procedure Code Tables

Recent Official Notices

Patient-Centered Medical Home (PCMH) 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.

- 6-month activities by 6/30/2025
- 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
A. Identify top 10% of high-priority patients	✓		
B. Make available 24/7 access to care.		✓	
C. Capacity to receive direct e-messaging from patients.		✓	
D. Childhood / Adult Vaccination Practice Strategy.		✓	
E. Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours.		✓	
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 B: Make available 24/7 access to care

Activity B Deadline: 6/30/2025
1. Provide telephone access to a live voice (e.g., an employee of the primary care physician or an answering service) or to an answering machine that immediately pages an on-call medical professional 24 hours per day, 7 days per week. a. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date. b. The on-call professional must: i. Provide information and instructions for treating emergency and non-emergency conditions, ii. Make appropriate referrals for non-emergency services, and iii. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed. 2. Response to non-emergency after-hours calls must occur within 30 minutes. A call must be treated as an emergency if made under circumstances where a prudent layperson with an average knowledge of health care would reasonably believe that treatment is immediately necessary to prevent death or serious health impairment. a. PCPs must make the after-hours telephone number known by all patients; posting the after-hours number on all public entries to each site; and including the after-hours number on answering machine greetings. 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 C: Capacity to receive direct e-messaging from patients

Activity C Deadline: 6/30/2025
1. Indicate if the practice has the capacity to use electronic messaging to communicate with patients. a. Indicate if the practice currently uses e-messaging and describe the method used.

b. Indicate if the messaging system is secure. c. Indicate if the messaging system meets HIPAA guidelines. 2. If the practice does not use e-messaging, indicate if a plan has been developed to implement the use of e-messaging. 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 D: Childhood/Adult Vaccination Practice Strategy

Activity D Deadline: 6/30/2025
• Indicate and describe the practice's implemented process to deliver immunization to both, when applicable, the pediatric and adult population leading into administration of immunization for the upcoming year. • Indicate if there is an implemented process to identify vaccination gaps in care for both, when applicable, the pediatric and adult population. • Indicate the ability to document historic immunization data into an EHR and review on each visit. • Indicate the capability to submit data electronically to immunization registries or immunization information systems. • 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 E: Join SHARE or participate in a network that delivers hospital discharge information to practice within 48 hours

Activity E Deadline: 6/30/2025
1. Indicate if the practice has joined SHARE.

a. Indicate the ability to access inpatient discharge information via SHARE. b. Indicate the ability to access patient transfer information via SHARE. 2. If the practice has not joined SHARE, indicate if the practice participates in a network that delivers hospital discharge information to the practices within 48 hours of discharge. 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.

ReviewPoint 2.0

AFMC hosted a webinar on March 20, 2025, to provide information and explain the benefits of submitting retrospective reviews electronically using ReviewPoint 2.0. ReviewPoint is AFMC's health utilization management provider portal, where requested records for retrospective reviews can be submitted, the status of reviews is monitored, and a reconsideration request for a denied claim is submitted. If you'd like to review the webinar recording and slide deck, please visit https://medicaid.afmc.org/provider-relations-policy-education/webinars. ■

What's New for Arkansas Medicaid Providers

Official notices posted from January 1, 2025 – March 31, 2025. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
Modifier JG (340B Acquired Drug) End Dated by CMS	01/03/2025	Procedure Codes
COVID-19 and Influenza Coverage for Non-Vaccine for Children (VFC) Pharmacies	01/17/2025	Procedure Codes
Update to Procedure Code A4648 Prior Authorization (PA) Requirement	01/24/2025	Procedure Codes
REVISED: COVID-19 and Influenza Coverage for Non-Vaccine for Children (VFC) Pharmacies	01/24/2025	Procedure Codes
Covered Servies for Sexual Abuse Exams	01/30/2025	Procedure Codes
Rate Updates	02/28/2025	Procedure Codes
Coverage for Procedure Codes 38220, 38221, and 38222	03/06/2025	Procedure Codes
2025 Annual and Quarter 1 Healthcare Common Procedure Code System Level II (HCPS) Code, Current Procedural Terminology (CPT), and ASC Code Conversion	03/06/2025	Procedure Codes
Inpatient MUMP Claims Processing Changes	03/13/2025	Billing Instruction
Coverage for Procedure Code 58674	03/24/2025	Procedure Codes

Messages for AR Medicaid Providers

TO: Health Care Providers – All Providers

DATE: January 3, 2025

SUBJECT:Modifier JG (340B Acquired Drug) End Dated by CMS

I. General Information

CMS has end dated modifier JG (340B Acquired Drug) as of 12/31/2024 as part of the 2025 HCPCS Annual Updates. When billing for dates of service 1/1/2025 and forward, Arkansas Department of Human Services will no longer pay 340B acquired drug claim details when billed with modifier JG.

Beginning with dates of service 1/1/2025, the appropriate modifiers to appended for 340B acquired drug claim details are:

- TB (340B Drugs)
- U7 (Orphan Drugs)
- U7 UA (All other drugs purchased outside of the 340B program)

For more information, please reference the CMS Publication MLN 4800856 located at https://www.cms.gov/files/document/mln4800856-medicare-part-b-inflation-rebate-guidance-use-340b-modifier.pdf

Any claim adjustments needed due to modifier JG being termed will be the responsibility of the provider. All claim submissions and adjustments should be received prior to the 365-day filing deadline.

TO: Health Care Providers – All Inpatient

DATE: March 13, 2025

SUBJECT: Inpatient MUMP Claims Processing Changes

I. General Information

Effective 3/25/2025, Inpatient providers can now submit claims spanning multiple Prior Authorization (PA) line items with continuous authorized dates under the same PA, without cutting back or denying. Claims will continue to rely on the PA for processing and decrementing the days to the corresponding PA line items under the same PA.

A continuous date is defined as a date without pause or interruption. If authorized dates are not continuous, the claim will only pay for the dates of service for the PA line item where the effective date does not align with the authorized end date of the previous PA line item, and the remainder will be cut back until the authorized date is reestablished as continuous.

Continuous dates are determined by adding one day to the end date of the current segment, which must align with the effective date of the subsequent segment. Prior Authorizations are no longer required for the first four days of an inpatient stay, even if the difference between the To Date of Service (TDOS) and admit date plus one exceeds four days.

Example of Continuous Dates: Line item 1 – 01/05/2025 – 01/10/2025

Line item 2 – 01/11/2025 – 01/18/2025

Line item 3 – 01/19/2025 - 01/24/2025

A new Explanation of Benefits (EOB) will post to paid claims for any cutbacks due to PA units being exhausted for the date of service (DOS) billed. This EOB will instruct the provider to request a PA extension and rebill, rather than writing off the charges.

- EOB 9012 – Cutbacks due to PA units exhausted. Request PA extension and rebill.

Additionally, CARC 151 and RARC N435 will be included on the EOB and the 835 file, indicating that a PA extension and rebill are required for the inpatient claim to adjudicate properly.

- CARC 151: Payment Adjusted because the payer deems the information submitted does not support this many/frequency of services.
  - For clarification, the assignment of CARC 151 is not an indication that the system is determining the medical necessity of the inpatient stay.
- N435: Exceeds number/frequency approved/allowed within time period without support documentation

TO: Health Care Providers – Hospital and Physician

DATE: March 24, 2025

SUBJECT: Coverage for Procedure Code 58674

I. General Information

The Arkansas Department of Human Services has updated coverage for procedure code 58674, retroactive to 3/1/2024, under the contracts as noted in the table below.

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

Proc Code	Description	Provider Contract	Modifier	PA	Med Rev	Gender
58674	LAPS ABLTJ UTERINE FIBROIDS	AMBSC	SG	Y	Y	F
		ASTSG	80, 81, 82	Y	Y	F
		MEDSV		Y	Y	F

TO: ALL INPATIENT PROVIDERS **RE: MUMP INPATIENT**

Effective 3/25/2025: Inpatient providers can now submit claims spanning multiple Prior Authorization (PA) line segments with continuous authorized dates under the same prior PA, without cutting back or denying. Claims will continue to rely on the PA for processing and allocate the days to the corresponding PA line items under the same PA.

However, if authorized dates are not continuous, the claim will be reduced starting from the From Date of Service (FDOS) until continuity of authorized dates is reestablished.

Continuous dates are defined as follows: The end date of the current segment plus one day must match the effective date of the next segment. If the end date of the one PA line item is the same as the effective date of the next line item, this is considered overlapping, not continuous.

Prior Authorizations are no longer required for the first four days of an inpatient stay, even if the difference between the To Date of Service (TDOS) and admit date plus one exceeds four days.

A new Explanation of Benefits (EOB) will post to paid claims for any cutbacks due to PA units being exhausted for the Date of Service (DOS) billed. This EOB will instruct the provider to request a PA extension and rebill, rather than writing off the charges.

- EOB 9012 – Cutbacks due to PA units exhausted. Request PA extension and rebill.

Additionally, CARC 151 and RARC N435 will be included on the EOB and the 835 file, indicating that a PA extension and rebill are required for the inpatient claim to adjudicate properly.

- CARC 151: Payment Adjusted because the payer deems the information submitted does not support this many/frequency of services.
- N435: Exceeds number/frequency approved/allowed with time period without support documentation.

TO: HOSPITAL, INDEPENDENT LAB, NURSE PRACTITIONER, AND PHYSICIAN PROVIDERS **RE: DIAGNOSIS GROUP 700 UPDATED**

A diagnosis from group 700 (CYSTIC FIBROSIS DIAGNOSIS GROUP) is required when billing procedure codes 81220-81224. Diagnosis Group 700 has been updated to include the following diagnosis codes:

Z130 - ENCNTR SCREEN FOR DIS OF THE BLD/BLD-FORM ORG/IMMUN MECHNSM

Z131 - ENCOUNTER FOR SCREENING FOR DIABETES MELLITUS

Z1321 - ENCOUNTER FOR SCREENING FOR NUTRITIONAL DISORDER

Z13220 - ENCOUNTER FOR SCREENING FOR LIPOID DISORDERS

Z13228 - ENCOUNTER FOR SCREENING FOR OTHER METABOLIC DISORDERS

Z31430 - ENCNTR FEM FOR TEST FOR GENETC DIS CARRIER STAT FOR PRO MGMT

Claims analysis will be performed going back one year.

TO: PHARMACY PROVIDERS

RE: PRIME THERAPEUTICS PHARMACY POINT OF SALE SYSTEM WILL BE DOWN

Effective October 1, 2024, detail-level billing is now required for Medicare Crossover Non-COBA claims. This change aims to ensure that claims are processed accurately. DHS recognizes that this may be a new billing method for some providers and may initially require additional time for claim submission. To support providers with detail-level billing, job aids have been provided outlining the necessary steps for submitting a claim. The AFMC MMIS Outreach Specialist Team is also available to address any questions or concerns regarding this new process.

TO: PHARMACY AND PROSTHETICS PROVIDERS

RE: BILLING MEDICAID WHEN A MEMBER'S OTHER INSURANCE COVERS DIABETIC SUPPLIES UNDER DURABLE MEDICAL EQUIPMENT (DME)

Prime Therapeutics will be performing maintenance to the pharmacy point of sale system beginning Saturday, March 29 at 10:00 PM CT and lasting approximately 15 minutes, until 10:15 PM CT. The pharmacy point of sale claims system will be down during this time frame.

TO: AREA HEALTH EDUCATION CENTER (AHEC); ARKIDS FIRST-B; EARLY INTERVENTION DAY TREATMENT (EIDT); HEARING SERVICES; OCCUPATIONAL THERAPY, PHYSICAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES; PHYSICIAN; AND VISUAL CARE

RE: ARKIDS HEARING/ VISION SCREENINGS

Arkansas Department of Human Services has updated the system to align with the EPSDT provider manual to prevent periodic hearing and vision screenings from being reimbursed on the same day or within 7 days of a medical screening.

The system has also been updated to bypass co-pay for ARKids for procedure 99173 - VISUAL ACUITY SCREEN.

Messages for Remittance Advices dated March 27, 2025 – April 3, 2025

TO: SPECIFIED PROVIDERS

RE: ACCOUNTING CODE ERROR

Your RA for the March 28 financial cycle will include one or more expenditures and one or more account receivables that will have a net zero effect on your payment. There was an accounting code error on one or more of your 09/05/2024 account receivables that we need to correct. You will see an expenditure code of 0815 and an account receivable code of 0950. Again, the net effect of your payment will be zero. We regret the inconvenience this may cause.

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

Provider Relations Outreach Specialists Information Sheet

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

AFMC OUTREACH SPECIALISTS

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

Manager, Outreach Services

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

Supervisor, Provider Relations

Kellie Cornelius **501-804-2501**
kcornelius@afmc.org

Outreach Specialists

Provider Relations **501-804-0184**
providerrelations@afmc.org

Shawna Branscum.....**501-804-2373**
sbranscum@afmc.org

Kimberly Breedlove ...**501-553-7642**
kbreedlove@afmc.org

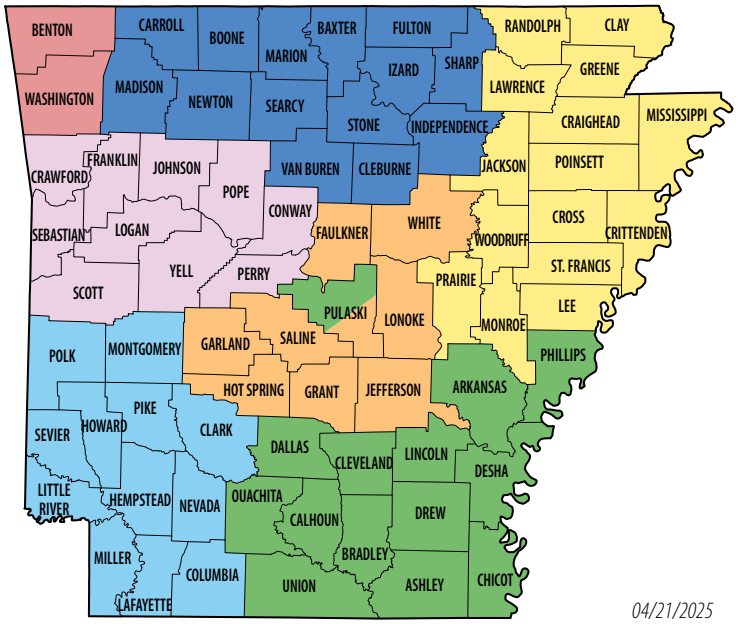
Jackie Clarkson.....**501-553-7665**
jclarkson@afmc.org

Carla Hestir.....**501-804-2901**
chestir@afmc.org

Connie Riley.....**501-545-7873**
criley@afmc.org

Supervisor, Outreach Logistics

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



04/21/2025

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

In-state toll free **800-457-4454**
Local & out-of-state **501-376-2211**

Gainwell Technologies Services

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

ARMedicaid

CONNECTCARE - BENEFICIARY SERVICES

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

• Toll free **800-275-1131**

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

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

VOICE RESPONSE SYSTEM - PCP ASSIGNMENT

• Toll free **800-805-1512**

PCMH QUESTIONS..... PCMH@afmc.org

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

Q4 SFY 2025
(April–June 2025)

- AR Medicaid Provider Manuals and Notifications
- Health Care Programs
- PCMH Activities Tracked for Practice Support
- ReviewPoint 2.0
- Upcoming Changes for Preferred Blood Glucose Meters

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