

ARKANSAS PROVIDER MEDICAID UPDATE

Q4 SFY 2026
(April–June 2026)



What's New for Arkansas Medicaid Providers

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



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Five Year Medicaid Provider Revalidation Requirement

Revalidation is required every five years for all provider types except Provider Type 95, which is exempt. The Arkansas Medicaid Provider Portal automatically generates notification letters to advise providers the date their enrollment will expire. Providers are strongly encouraged to submit revalidation at least 60 days prior to this revalidation due date to avoid disruption. All required documentation must be submitted before the expiration date.

Beginning March 2, 2026, when logging into the Health Care Portal, providers will see a revalidation link along with their assigned revalidation deadline date.

[Start your revalidation](#)

Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT) Providers Updated Provider Revalidation Action Required

Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT) providers (type 24) are required to comply with the standard revalidation requirement every five (5) years, in accordance with 42 CFR § 455.414. Due to an error, EIDT and ADDT providers who should have submitted a revalidation application were not informed. As a result, more than five (5) years have passed since the provider's enrollment application (initial enrollment, re-enrollment, or revalidation) was last submitted for this provider type.

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

Beginning March 2, 2026, providers can review their revalidation date in the Health Care Portal.

Who Must Revalidate

EIDT and ADDT providers with an initial enrollment date older than five years will be required to complete a revalidation application to maintain continued enrollment.

Portal Updates

When logging into the portal, providers will see a revalidation link along with their assigned revalidation deadline date.

- Providers whose revalidation date falls within the next 60 days should complete their revalidation during this initial cycle using the revalidation link provided.
- Providers with a revalidation date scheduled later should wait and complete their revalidation at the future date displayed in the portal.

Providers will have 60 days to complete revalidation, but DHS requests that applications be submitted as soon as possible.

Required Documentation

The following items are required to complete the revalidation process:

- W 9 (2024 version)
- IRS Letter
 - › Required for the enrolling provider and any listed entity owners
- EFT Form and Bank Letter
 - › Only required if updating EFT information
- DPSQA Certificates
 - › Must match service location
- ACA Fee (proof of paid fee)
 - › Required at the time of revalidation
 - › Applies to EIDT and ADDT (type 24) providers
 - › A link to pay the fee online is available in the portal
 - › A paid receipt must accompany the revalidation application

Failure to complete revalidation will result in termination as an Arkansas Medicaid provider.

For questions concerning revalidation, contact Arkansas Medicaid Provider Enrollment at (800) 457-4454 or visit the [Provider Enrollment Information webpage](#).

State Fiscal Year (SFY) Benefit Limit Exhaustion and Extension of Benefits Requests

Section 220.000 of the Arkansas Medicaid Physician Manual states benefit limits are the limits on the **quantity** of covered services Medicaid-eligible beneficiaries may receive. Medicaid-eligible beneficiaries are responsible for payment for services beyond the established benefit limits, unless the Division of Medical Services (DMS) authorizes an extension of a particular benefit.

If a service is denied for exceeding the benefit limit, and the Medicaid beneficiary had elected to receive the service by written informed consent prior to the delivery of the service, the Medicaid beneficiary is responsible for the payment, unless that service has been deemed not medically necessary.

Benefit extensions are considered after the service has been rendered and the provider has received a denial for “benefits exhausted.” DMS considers requests for benefit extensions based on the medical necessity of the service. If a Medicaid provider chooses to file for an extension of benefits and is denied due to the service not being medically necessary, the beneficiary is not responsible for the payment. Once the extension of benefits request has been initiated on a specific service, the provider cannot abort the process before a final decision is rendered.

The Arkansas Department of Human Services, Division of Medical Services considers requests for benefit extensions based on the medical necessity of the service. Sections 229.000 through Section 229.120 and Section 131.000 points A and C outline benefit extension request procedures. DMS reviews extension of benefits requests for Home Health, personal care, diapers and medical supplies. DHS or its designated vendor reviews extension of benefits requests for physician, lab, radiology and machine tests, using form DMS-671. All personal care services for beneficiaries under age 21 are reviewed by the contracted Quality Improvement Organization (QIO) AFMC.

An extension of benefits may be requested electronically via the Medicaid Management Information System (MMIS). The MMIS job aid outlining the steps to be followed when making a request is located here: [MMIS Prior Authorization Job Aid](#).

229.100 **Extension of Benefits for Diagnostic Laboratory and Radiology/Other, Physician Office, and Outpatient Hospital Services** **7-1-22**

A. The Medicaid Program’s diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.

1. Diagnostic laboratory services benefits are limited to five hundred dollars (\$500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars (\$500) per SFY.
2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.

[View or print the essential health benefit procedure codes.](#)

- B. Requests for extension of benefits for diagnostic laboratory, radiology/other, physician office, and outpatient services must be submitted to Department of Human Services (DHS) or its designated vendor.
[View or print contact information to obtain the DHS or designated vendor step-by-step process for extension of benefits.](#)
- 1. Requests for extension of benefits are considered only after a claim is filed and is denied because the patient's benefit limits are exhausted.
- 2. Submit a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exhausted benefits with the request. Do not send a claim.
- C. A request for extension of benefits must be received within ninety (90) calendar days of the date of the benefits-exhausted denial.
- D. Additional information will be requested as needed to process a benefit extension request. Reconsiderations of additionally requested information are not available. Failure to provide requested information within the specified time will result in a technical denial.
- E. Correspondence regarding benefit extension requests and requests for reconsideration of denied benefit extension requests, does not constitute documentation or proof of timely claim filing.

229.110 **Completion of Form DMS-671, "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services"** **7-1-22**

- A. The Medicaid Program's diagnostic laboratory services, and radiology/other services benefit limits apply to the outpatient setting.
 - 1. Diagnostic laboratory services benefits are limited to five hundred dollars (\$500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars (\$500) per SFY.
 - 2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
 - 3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.
- B. Requests for extension of benefits for clinical services (physician's visits), outpatient services (hospital outpatient visits), diagnostic laboratory services (laboratory tests), and radiology/other services must be submitted to DHS or its designated vendor for consideration.
[View or print contact information to obtain the DHS or designated vendor step-by-step process to complete request.](#)
- 1. Consideration of requests for extension of benefits requires correct completion of all fields on the "Request for Extension of Benefits for Clinical, Outpatient, Diagnostic Laboratory, and Radiology/Other Services" form (Form DMS-671). [View or print Form DMS-671.](#)
- 2. Instructions for accurate completion of Form DMS-671 (including indication of required attachments) accompany the form. All forms are listed and accessible in [Section V](#) of each Provider Manual.

- A. The Medicaid Program's diagnostic laboratory services and radiology/other services benefit limits apply to the outpatient setting.
 - 1. Diagnostic laboratory services benefits are limited to five hundred dollars (\$500) per State Fiscal Year (SFY: July 1 through June 30), and radiology/other services benefits are limited to five hundred dollars (\$500) per SFY.
 - 2. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring/machine tests, such as electrocardiograms (ECG or EKG).
 - 3. Diagnostic laboratory services and radiology/other services defined as Essential Health Benefits by the U.S. Preventive Services Task Force (USPSTF) are exempt from counting toward either of the two new annual caps.
- B. To request extension of benefits for any benefit limited service, all applicable records that support the medical necessity of extended benefits are required.
- C. Documentation requirements are as follows.
 - 1. Clinical records must:
 - a. Be legible and include records supporting the specific request;
 - b. Be signed by the performing provider;
 - c. Include clinical, outpatient, or emergency room records (as applicable) for dates of service in chronological order;
 - d. Include related diabetic and blood pressure flow sheets;
 - e. Include a current medication list for the date of service;
 - f. Include the obstetrical record related to a current pregnancy (when applicable); and
 - g. Include clinical indication for diagnostic laboratory and radiology/other services ordered with a copy of orders for diagnostic laboratory and radiology/other services signed by the physician.
 - 2. Diagnostic laboratory and radiology/other reports must include:
 - a. Clinical indication for diagnostic laboratory and radiology/other services ordered;
 - b. Signed orders for diagnostic laboratory and radiology/other services;
 - c. Results signed by the performing provider; and
 - d. Current and all previous ultrasound reports, including biophysical profiles and fetal non-stress tests (when applicable).

229.130 Administrative Reconsideration and Appeals 6-1-25

- A. Medicaid allows only one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

DHS to launch soft implementation of ARHOME Work and Community Engagement Requirement Beginning July 1



ARKANSAS
DEPARTMENT OF
HUMAN
SERVICES

We Care. We Act.
We Change Lives.

For Immediate Release:

February 23, 2026

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DHS to launch soft implementation of work and community engagement requirement starting July 1

Coverage note: Division of County Operations Director Mary Franklin will be available to answer questions from media today at 1:30 p.m. Media must RSVP to attend in-person in Little Rock or virtually by emailing Gavin Lesnick at gavin.lesnick.dhs@dhs.arkansas.gov.

(LITTLE ROCK, Ark.) — The Arkansas Department of Human Services (DHS) will launch a soft implementation of new work and community engagement requirements for many Medicaid beneficiaries starting July 1, but no penalties will be in effect until January 1, 2027.

Under the new program, healthy adults enrolled in Arkansas Health and Opportunity for Me, or ARHOME, must work, volunteer, or go to school for at least 20 hours per week (80 hours per month). States that have expanded Medicaid are required under the federal budget bill signed into law last year to implement work and community engagement programs by Jan. 1, 2027. DHS will launch the full requirement on that date, and Arkansans who are not exempt and who do not comply could lose their coverage or be denied at application beginning then.

“Most Arkansans work hard to pay for their health insurance but for too long, Arkansas has subsidized healthy adults to stay on the sidelines. That’s a backward, broken system, and we will end it under this administration,” said Governor Sarah Huckabee Sanders. “I’m grateful to President Trump and congressional Republicans for paving the way for us to implement this

work requirement and look forward to the opportunity to bring smaller government, greater prosperity, stronger families, and better communities to Arkansas."

The work and community engagement requirement will apply to Arkansans aged 19 to 64 enrolled in ARHOME unless they are exempt. Exempt categories include pregnant and postpartum women, disabled veterans, caregivers, and those with special medical needs. Approximately 217,000 Arkansans were enrolled in ARHOME as of Feb 1.

The soft implementation will help the state further refine the program, educate beneficiaries, partners, and providers, identify areas where improvement is needed, and ensure that all ARHOME enrollees are aware of the new requirements before they go into effect fully.

"Finding a job brings purpose, meaning, and economic independence, which we know leads to better health," said DHS Secretary Janet Mann. "We want all Arkansans to be engaged in their health and well-being, and this program is a key step that will help those served by our Medicaid expansion program improve their lives. This also helps ensure that our finite Medicaid resources support those who need them, and not those who could work but choose not to do so."

Under the soft implementation starting on July 1, DHS will begin running automated processes to determine if beneficiaries are exempt, meeting, or not meeting the community engagement requirement. While no penalties will be in place for 2026, beneficiaries will be notified of their status based on those automated checks so they can become better familiar with the requirement and ensure they are positioned to meet the requirement in 2027.

DHS is working with partners including sister agencies, and is in the process of obtaining a vendor for a customer service center that will perform outbound communications including calls to verify community engagement status when the automated processes do not confirm it. That vendor will begin reaching out to beneficiaries in December leading up to the full launch of the program, and beneficiaries will also be able to report activities by phone, online, or at their local DHS county office. Starting on Jan. 1, 2027, beneficiaries who do not meet the community engagement requirement will have 30 days to show compliance before their Medicaid benefits are suspended.

DHS remains in communication with the Centers for Medicare and Medicaid Services (CMS) and expects additional guidance as specific program policies are developed and implemented. DHS will communicate updates to beneficiaries through a variety of methods in the coming weeks and months. To ensure that beneficiaries receive important program information, they should ensure their mailing address, phone, and email are up-to-date, and they can sign up for email and text alerts in addition to mailed notices online through [Access. Arkansas.gov](https://www.access.arkansas.gov). Additional details about updating contact information are posted at [ar.gov/update](https://www.ark.gov/update).

In January of last year, DHS announced plans to implement a work and community engagement program called Pathway to Prosperity. That waiver was pending with CMS when the new requirements from the federal budget bill were signed into law. This new approach preserves the overall goal of Pathway to Prosperity to help Medicaid beneficiaries build skills and attain economic independence while also meeting all the requirements outlined in the federal law.

Update Arkansas

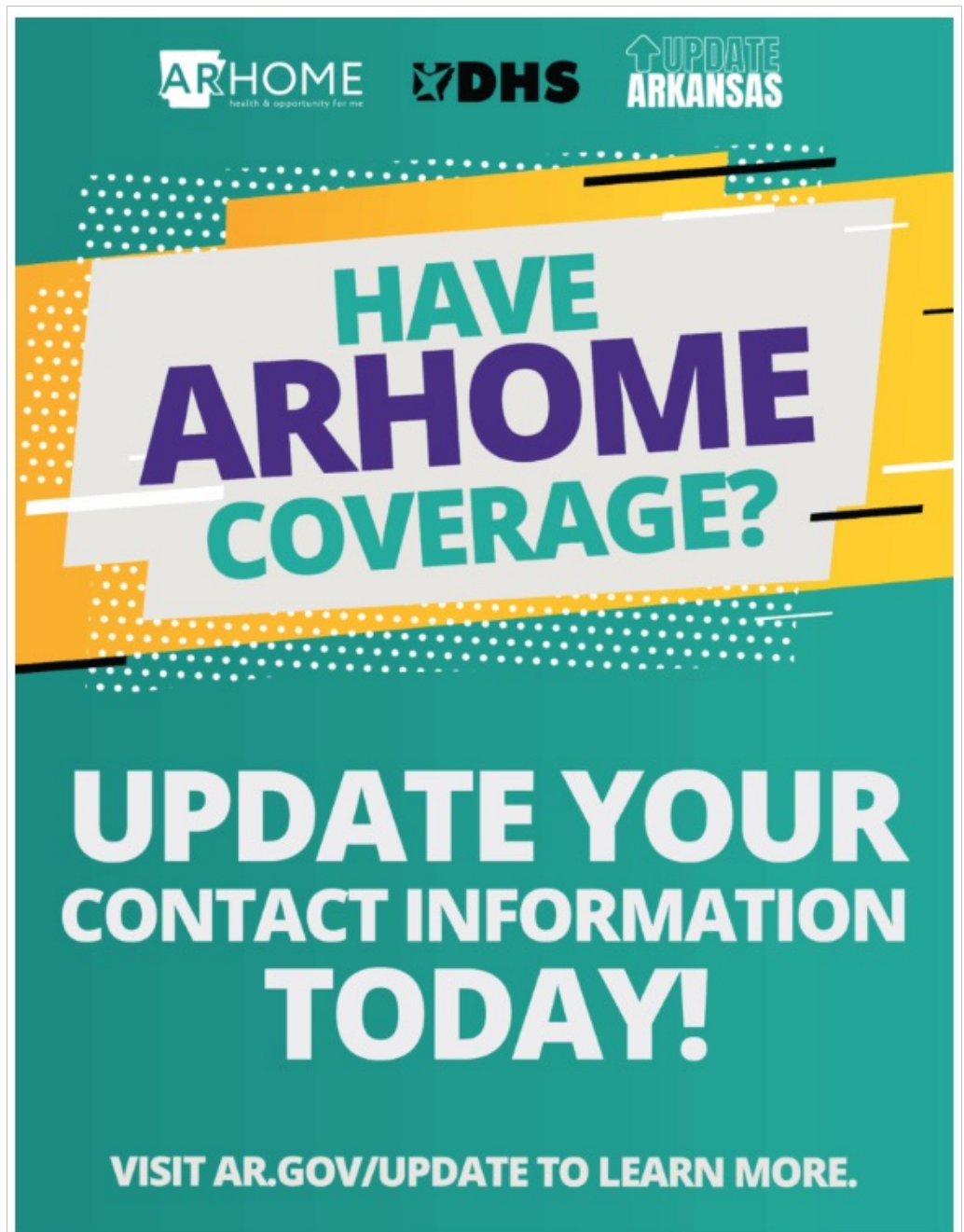
What To Do Now

ARHOME Beneficiaries need to update their contact information and sign up to receive text and email alerts.

Here's how to update their contact information and sign up for text and email alerts:

1. Call the Access Arkansas hotline at **1-855-372-1084**
2. Go online at access.arkansas.gov or ar.gov/accessanywhere
3. Visit their local **DHS county office** to update their information (find your local office here)
4. Click [HERE](#) to watch a short video on how to sign up for text and email alerts

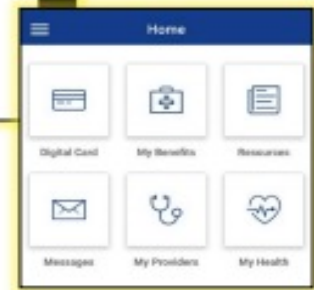
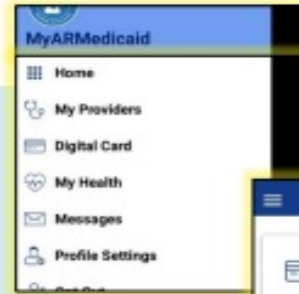
Update Arkansas



MyARMedicaid Mobile App Flyers are now available in English, Spanish, and Marshallese



Download the MyARMedicaid App



BENEFITS

- View claims that Medicaid has paid for you
- View doctors or providers you have seen
- View medical visits or procedures you have had
- View your prescriptions and immunization records
- Access your digital Medicaid Card
- Search for providers
- Receive important notifications

HOW TO SIGN UP

Must be age 18+ to register

- **On your smartphone**
 - Go to the Apple App Store or Google Play.
 - Download the MyARMedicaid app.
 - Create an account and log in to see the benefits.



- **Through the web**
 - Go to the MyARMedicaid website at <https://mdp.mmis.arkansas.gov/>.
 - Create an account and log in to see the benefits.

Donaghey Plaza, P.O. Box 1437, Little Rock, AR 72203

501.682.1001

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What's New for Arkansas Medicaid Providers

CMS Moratorium on Newly Enrolling DME Supplier Types

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

Effective February 27, 2026, CMS implemented a six-month nationwide moratorium on new Medicare enrollment for certain Durable Medical Equipment (DME) supplier types to prevent fraud, waste, and abuse, which may be extended in additional six-month increments. While currently enrolled providers are unaffected, failure to complete Medicare or Medicaid revalidation could lead to termination as an Arkansas Medicaid provider and an inability to re-enroll during the moratorium. For more details, read the [CMS Moratorium Q&A](#).

Official notices posted from January 1, 2026 – March 31, 2026. Please click [here](#) to view details for each notice and other helpful information for Arkansas Medicaid providers.

Title	Posted Date	Category
Coverage for Casgevy (J3392) and Lyfgenia (J3394) for the Sickle Cell Gene Therapy Model	03/24/2026	Procedure Codes
Act 515 - Allow Providers Additional Time to Respond to Adverse Decisions	03/24/2026	Extended Appeal Period
2026 Annual and Quarter 1 Healthcare Common Procedure Coding System Level II (HCPCS) Code, Current Procedural Terminology (CPT), and ASC Code Conversion	03/10/2026	Procedure Codes
Other Medical Service PA Process Type Now Available for Carved-Out Drugs and Services	03/02/2026	Prior Authorizations
REVISED: 2025 Quarter 2 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion	02/11/2026	Procedure Codes
Drugs and Services Carved Out of Physician Administered Drug Prior Authorizations Submitted to Prime Therapeutics	02/02/2026	Prior Authorizations
Coverage for Procedure Code D9245	01/16/2026	Procedure Codes
Eating Disorder Services – No PCP Referral Required	01/07/2026	PCP Referral
Extension of Prior Authorization (PA) for Hyperalimentation Services if the Beneficiary has a Chronic Condition	01/06/2026	Prior Authorizations

OFFICIAL NOTICE

TO: Health Care Providers – Dental Providers

DATE: January 16, 2026

SUBJECT: Coverage for Procedure Code D9245

I. General Information

In the 2026 Annual HCPCS File from CMS, procedure code D9248 was termed. Therefore, Arkansas Department of Human Services has added coverage for D9245 under the Dental (Child) Contract. The following applies:

- Procedure codes that are identified as new codes will become payable for dates of service on or after 1/1/2026.
- Procedure codes that are identified as terminated will become non-payable for dates of service after the end date provided.
 - › **NOTE:** For claims with CMS terminated procedure codes, Arkansas Department of Human Services will perform a mass adjustment to recoup any claim details in paid status. Refer to [Section III](#) for list of termed/end dated procedure codes.
- Requests for PA revisions should be submitted by the provider to the approving entity.
- Any claim adjustments needed due to coding changes will be the responsibility of the provider.
- All claim submissions and adjustments should be received prior to the 365-day filing deadline.

II. HCPCS Procedure Codes Payable to Dentists

The following information is related to procedure codes payable to Dentists:

Proc Code	Description	Provider Contract	PA Req
D9245	ADMIN MOD SEDATION-ENTERAL	DENTC	Y

III. HCPCS Procedure Codes Termed/End Dated

The following procedure code is termed as of 12/31/2025:

Proc Code	Description
D9248	SEDATION (NON-IV)

OFFICIAL NOTICE

TO: Health Care Providers – Physicians

DATE: January 7, 2026

SUBJECT: Eating Disorder Services – No PCP Referral Required

I. General Information

Effective February 1, 2024, the Arkansas Medicaid Physician Manual was updated with Section 172.100. This section added services that do not need a Primary Care Provider (PCP) referral.

Multi-Disciplinary Eating Disorder services/programs are covered under Category Y of this section, which states:

“Other services... when the Medicaid Program determines that restricting access to care would be detrimental to the patient’s welfare or to program integrity or would create unnecessary hardship.”

With this clarification, patients requiring treatment for an eating disorder can access treatment directly, without a PCP referral, resulting in more timely and critical treatment for this disorder.

All providers of 172.100 services that do not require a PCP referral are expected to regularly communicate treatment updates to the PCP who is responsible for documenting all services as part of routine health supervision and Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) visits. Such communication ensures complete and coordinated care.

Diagnostic codes included in eating disorders PCP referral exemption are as follows and should be included on the claim.

Diagnosis	Description
F5000	ANOREXIA NERVOSA, UNSPECIFIED
F5001	ANOREXIA NERVOSA, RESTRICTING TYPE
F50010	ANOREXIA NERVOSA, RESTRICTING TYPE, MILD
F50011	ANOREXIA NERVOSA, RESTRICTING TYPE, MODERATE
F50012	ANOREXIA NERVOSA, RESTRICTING TYPE, SEVERE
F50013	ANOREXIA NERVOSA, RESTRICTING TYPE, EXTREME
F50014	ANOREXIA NERVOSA, RESTRICTING TYPE, IN REMISSION
F50019	ANOREXIA NERVOSA, RESTRICTING TYPE, UNSPECIFIED
F5002	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE
F50020	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, MILD
F50021	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, MODERATE
F50022	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, SEVERE
F50023	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, EXTREME
F50024	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, IN REMISSION

Diagnosis	Description
F50029	ANOREXIA NERVOSA, BINGE EATING/PURGING TYPE, UNSPECIFIED
F502	BULIMIA NERVOSA
F5021	BULIMIA NERVOSA, MILD
F5022	BULIMIA NERVOSA, MODERATE
F5023	BULIMIA NERVOSA, SEVERE
F5024	BULIMIA NERVOSA, EXTREME
F5025	BULIMIA NERVOSA, IN REMISSION
F508	OTHER EATING DISORDERS
F5081	BINGE EATING DISORDER
F50810	BINGE EATING DISORDER, MILD
F50811	BINGE EATING DISORDER, MODERATE
F50812	BINGE EATING DISORDER, SEVERE
F50813	BINGE EATING DISORDER, EXTREME
F50814	BINGE EATING DISORDER, IN REMISSION
F50819	BINGE EATING DISORDER, UNSPECIFIED
F5082	AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER
F5083	PICA IN ADULTS
F5084	RUMINATION DISORDER IN ADULTS
F5089	OTHER SPECIFIED EATING DISORDER

OFFICIAL NOTICE

TO: Health Care Providers – Hyperalimentation

DATE: January 6, 2026

SUBJECT: Extension of Prior Authorization (PA) for Hyperalimentation Services if the Beneficiary has a Chronic Condition

I. General Information

Arkansas Department of Human Services made changes to allow providers to extend prior authorization (PA) for hyperalimentation services through the provider portal, if the beneficiary's condition is chronic. An existing PA- whether partially approved, approved with modifications, or fully approved- may be extended once per 12-month period. Please note, the extension must be submitted within 12-months of the original prior authorization's effective date. The extension will be copied with the same procedure code and modifier from the original PA. Providers will need to specify the number of units requested for the extension.

II. PA Extension Process

1. Log into the Provider Portal and access the original PA.
 - Navigate to the Care Management Tab.
 - Click "View Authorization Status."
 - Under Search Options, enter the PA Tracking Number and click "Search."
 - The original PA will appear in the Search Results
2. Click on the PA Tracking Number to access the PA you wish to extend.
3. In the Beneficiary Information Panel, a message will display:
 - "Beneficiary's condition is chronic and is unlikely to change."
 - Check the checkbox to confirm.
4. The Service Detail Panel will open, showing each original PA line available for extension.
5. For each line to extend, check the 'Extended' box.
 - A new line will be generated, using the same procedure code and modifiers as on the original PA
 - Units/dollars field will match the original PA.
 - The Authorization Effective Date auto populate as one day after the original authorization End Date on the original PA line.
6. Enter the new "To Date" in the To Date field (up to an additional 6 months of service).
7. Enter the requested number of units for the service line.
8. Click "Save Extension" to save your changes.
9. Repeat steps 5-8 for each PA line you wish to extend.
10. Upload any new attachments to the extension request.
 - Attach the current prescription (must be the same formula and calories required).
 - Any change would be considered a new request/not chronic.
 - › The chronic request would be denied and returned to provider requiring for correction.
11. Click "Submit Attachments" to submit the new attachments.
 - A confirmation message will display once attachments are received.

12. Click “Submit Extension” to submit the request.

- You will be prompted to confirm that all necessary attachments and PA lines are included.
 - › Clicking “Yes” submits the request and displays a confirmation page.
 - › Clicking “No” returns you to the request for further editing.

III. Important Information

Only one extension will be allowed per 12-month period.

The Chronic indicator will not be available if an extension has already been submitted for the PA.

The “To Date” on the extension must be within 12-months of the original Authorization Effective Date. Otherwise, an error message will appear:

- Extension must be requested within 12-months of the Authorized Effective date on the original PA.

IV. Contact Information for Obtaining Prior Authorization

When obtaining a Prior Authorization from the Arkansas Foundation for Medical Care (AFMC) please send your request to the following:

Arkansas Foundation for Medical Care	
In-state and out-of-state toll free for inpatient reviews, Prior Authorizations for surgical procedures and assistant surgeons only	1-800-426-2234
General telephone contact, local or long distance – Fort Smith	(479) 649-8501 1-877-650-2362
Fax for Molecular Pathology only	(479)-649-0799
Fax – General	(479) 649-0799
Fax – Physician Drug Reviews Only (PDR)	(479)-649-0799
Mailing address	Arkansas Foundation for Medical Care, Inc. P.O. Box 1508 Fort Smith, AR 72902
Physical site location	1101 South 21st Street Fort Smith, AR 72901
Office hours	8:00 a.m. until 4:30 p.m. (Central Time), Monday through Friday, except holidays
Web portal – AFMC	https://reviewpoint.afmc.org/s/login/
Web portal – Arkansas Medicaid	https://portal.mmis.arkansas.gov/armedicaid/provider/Home/tabid/135/Default.aspx

PCMH

Activities Tracked for Practice Support (PBPM Care Coordination Payment)

All Patient-Centered Medical Homes (PCMHs) are required to complete **all program activities by the specified deadlines**, submit the required **attestations**, and upload **supporting documentation** in the Quality Care Insight (QCI) provider portal to remain eligible for **per member per month (PBPM) care coordination payments**.

The table below outlines the activities due at the **3-month** and **6-month** milestones:

3-month activities: Due by **March 31, 2026**

6-month activities: Due by **June 30, 2026**

Highlighted items within the table reflect **updates from the Program Policy Addendum**. Please refer to the **2026 PCMH Program Policy Addendum** for additional details, including activities required at the **9-month** and **12-month** milestones.

For information regarding remediation requirements, please consult the **PCMH Provider Manual**.

Activity	3-Month	6-Month	9-Month	12-Month
A. Identify top 10% of high-priority patients	✓			
B. Identify Focus Area for Improvement	✓			
C. Make Available 24/7 Access to Care	✓			
D. Prescription Drug Monitoring Program (PDMP) Questions	✓			
E. Capacity to Receive Direct E-Messaging from Patients		✓		
F. Childhood/Adult Vaccination Practice Strategy		✓		
G. Join SHARE or Participate in Network		✓		

Register today for the AFMC MMIS Annual Billing Conference!

Thursday, April 30

9:00 a.m. - 4:00 p.m.

Benton Event Center / Benton, AR - In-person and virtual seats are available

The MMIS Outreach Team will host one centralized Annual Billing Conference for all Arkansas Medicaid providers. This event will be held at the Benton Event Center in Benton, AR.

The conference runs from 9:00 a.m. to 4:00 p.m., with a lunch break from noon to 1:00 p.m. Please note that lunch is not provided. To ensure space for all, in-person registration is limited 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.

[Register Here](#)

Agenda

Morning Session

- 9:00 – Welcome and Introduction
- 9:05 – 10:10 – AFMC MMIS Team
- 10:10 – 10:55 – Gainwell Provider Enrollment Updates
- 10:55 – 11:15 – Vendor Break
- 11:15 – 11:30 – Non-Emergency Transportation Program Updates
- 11:30 – 11:55 – Provider Relations Updates
- 11:55 – 1:00 – Lunch Break

Exhibitors

- AFMC Provider Relations/ DPSQA/Connect Care
- Acentra
- Diamond Plan
- First Connections
- MMIS
- Non-Emergency Transportation (NET)
- PASSEs - AR Total Care, CareSource, Empower and Summit

Afternoon Session

- 1:00 – 1:30 – AR Medicaid Updates
- 1:30 – 2:30 – PASSEs
- 2:30 – 2:45 – Vendor Break
- 2:45 – 4:00 – Panel Session

SAVE THE DATE

10TH ANNUAL ACES & RESILIENCE SUMMIT

VISIT
**AFMC.ORG/
ACESUMMIT**
FOR MORE
INFORMATION



ACEs26

**Thursday
September 17th, 2026**

North Little Rock Event Center
120 Main Street
North Little Rock, AR 72114



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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.

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Outreach Specialists

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 Kimberly Breedlove ... 501-553-7642
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 Jackie Clarkson 501-553-7665
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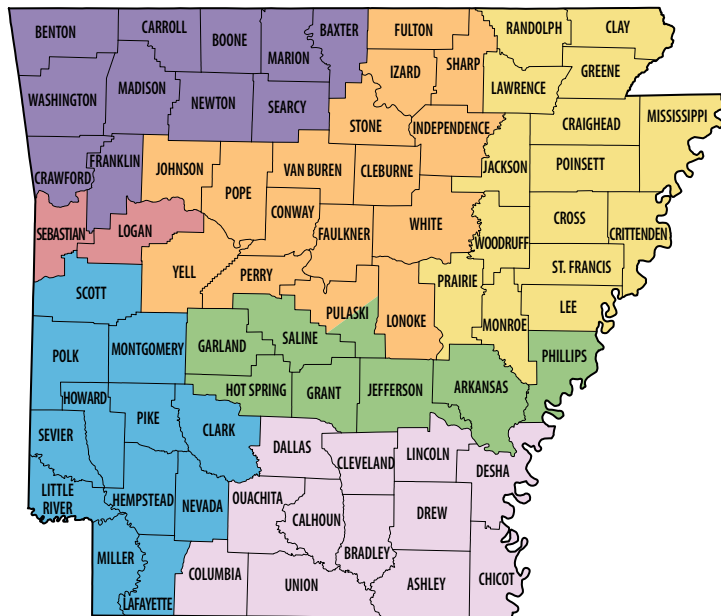
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Supervisor, Outreach Logistics

Tonyia Long 501-212-8686
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4/06/2026

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

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

In-state toll free 800-457-4454

Local and out-of-state 501-376-2211

Monday through Friday 8 a.m. until 5:00 p.m.

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES



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



ARKANSAS PROVIDER MEDICAID UPDATE

Q4 SFY 2026
(April–June 2026)

- AFMC MMIS Annual Billing Conference
- ARHOME Work and Community Engagement Requirement
- Benefit Limit Exhaustion and Extension of Benefits Requests
- MyARMedicaid Mobile App Resources
- PCMH Tracked Activities
- Provider Revalidation Requirement

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