

DEPARTMENT OF HEALTH, DIVISION OF MEDICAL SERVICES

SUBJECT: Physician Assistants and Clinical Nurse Specialists as Primary Care Providers (Concerning 20 CAR pts. 570, 600, 608, 610, 611, 614, 619, 622, 624, 625, 628, 631, 636. 646, 650, and Proposing 20 CAR pts. 654, 655)

DESCRIPTION:

Statement of Necessity

The Division of Medical Services (DMS) implements provisions of Act 482 of 2025 and provisions of Acts 303 and 872 of 2023 and completes the necessary state plan revisions to align reimbursement rules with current practice authority for physician assistants and clinical nurse specialists. The goal of this rule is to increase the number of providers available to meet the needs of Arkansas Medicaid beneficiaries and increase access to services in rural areas of the state. Physician assistants and clinical nurse specialists will be able to bill independently for services rendered to Medicaid beneficiaries and serve as primary care providers in the Medicaid Primary Care Case Management (PCCM) program.

Summary

The rule allows physician assistants and clinical nurse specialists to bill for services rendered to Medicaid beneficiaries at 80% of the physician's rate based on existing nurse practitioner methodology. Implementing the practice authority and reimbursement rules requires an Arkansas Medicaid State Plan Amendment (20 CAR 570), along with extensive revision of the Arkansas Medicaid Provider Manuals. The following manuals are revised by this rule:

- Section I – General Policy (20 CAR 600)
- ARKids-First B (20 CAR 608)
- Certified Nurse-Midwife (20 CAR 610)
- Child Health Services (EPSDT) (20 CAR 611)
- Counseling and Crisis Services (20 CAR 614)
- Federally Qualified Health Center (20 CAR 619)
- Home Health (20 CAR 622)
- Hospital-Critical Access Hospital-End Stage Renal Disease (20 CAR 624)
- Hyperalimentation (20 CAR 625)
- Life360 HOMES (20 CAR 628)
- Nurse Practitioner (20 CAR 631)
- Physicians-Independent Lab-CRNA-Radiation Therapy Center (20 CAR 636)
- Rural Health Clinic (20 CAR 646)
- Visual Care (20 CAR 650)
- Clinical Nurse Specialist (20 CAR 654 – NEW)
- Physician Assistant (20 CAR 655 – NEW)

The agency indicated that, after the rule was released for public comment, CMS requested some updates to the SPA coverage pages to remove language that was too limiting, and to improve precision, accuracy and consistency. The reimbursement pages

were updated to detail fee schedule language and alignment for physician reimbursement with the coverage pages.

PUBLIC COMMENT: A public hearing was held on this rule on May 27, 2026. The public comment period expired on June 8, 2026. The agency provided the following public comment summary:

Commenter's Name: David W Wroten, Executive Vice President, Arkansas Medical Society

COMMENT: The Arkansas Medical Society hereby submits the following comments regarding the proposed rule designed to implement provisions of Act 482 of 2025 and Act 303 and 872 of 2023. These comments specifically address the requirements of Act 482 of 2025 and Act 303 of 2023.

Act 303 of 2023 allows physician assistants to be identified as the treating provider in billing and claims processes and to file claims as the billing provider for medical services delivered by the physician. Subsequently, in 2025, Act 482 allows physician assistants to be recognized as primary care providers authorized to carry out the responsibilities of a primary care case manager under the Arkansas Medicaid program. The Arkansas Medical Society supported the passage of both statutes with the requirement that the physician assistant obtain the approval of his or her supervising physician.

Both Acts contain specific language requiring authorization from the supervising physician. This authorization requirement is noted in the proposed rule. However, what appears to be missing in the proposed rule is a process whereby the Arkansas Medicaid program verifies that the authorization was granted by the supervising physician. Act 482 of 2025 mandated a specific process for verifying authorization. This is stated in 20-77-154 (e):

When initially applying to the program to be recognized as a primary care provider and case manager under this section, a physician assistant shall provide a written authorization that is signed and dated by his or her supervising physician.

While this specific language was included in Act 482, we believe it is appropriate for verifying authorization under Act 303 as well. It is possible that given the length of the rule, we overlooked the language that requires written authorization be provided to Medicaid. But in the event the language is not currently in the rule, we request that it be added.

RESPONSE: The authorization requirement is listed in § 171.100 H. However, we agree this language should be better aligned with the requirements of § 20-77-154(e). This will be updated as follows:

H. Physician Assistants authorized by a supervising physician may choose to enroll as PCPs. When initially enrolling with Medicaid to be recognized as a primary care provider, a physician assistant shall provide written authorization

that is signed and dated by his or her supervising physician. In addition, the supervising physician must be actively enrolled in Arkansas Medicaid.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 482 of 2025. The Act, sponsored by Senator Clint Penzo, authorized the Arkansas Medicaid Program to recognize a physician assistant as a primary care provider.



Office of Policy and Rules

P.O. Box 1437, Slot S295, Little Rock, AR 72203-1437

P: 501.320.6383 F: 501.404.4619

May 8, 2026

Mrs. Rebecca Miller-Rice
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
#1 Capitol, 5th Floor
Little Rock, AR 72201

Dear Mrs. Rebecca Miller-Rice:

Re: Physician Assistants and Clinical Nurse Specialists as Primary Care Providers

Please arrange for this rule to be reviewed by the ALC-Administrative Rules Subcommittee. If you have any questions or need additional information, please contact me at 501-320-6383 or by emailing Mac.E.Golden@dhs.arkansas.gov.

Sincerely,

Mac Golden

Mac Golden
Attorney III
Office of Policy and Rules

Attachments

**QUESTIONNAIRE FOR FILING PROPOSED RULES WITH
THE ARKANSAS LEGISLATIVE COUNCIL**

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Medical Services
BOARD/COMMISSION DIRECTOR Elizabeth Pitman
CONTACT PERSON Mac Golden
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203-1437
PHONE NO. (501) 320-6383 EMAIL Mac.E.Golden@dhs.arkansas.gov
NAME OF PRESENTER(S) AT SUBCOMMITTEE MEETING
Elizabeth Pitman
PRESENTER EMAIL(S) elizabeth.pitman@dhs.arkansas.gov

INSTRUCTIONS

In order to file a proposed rule for legislative review and approval, please submit this Legislative Questionnaire and Financial Impact Statement, and attach (1) a summary of the rule, describing what the rule does, the rule changes being proposed, and the reason for those changes; (2) both a markup and clean copy of the rule; and (3) all documents required by the Questionnaire.

If the rule is being filed for permanent promulgation, please email these items to the attention of Rebecca Miller-Rice, miller-ricer@blr.arkansas.gov, for submission to the Administrative Rules Subcommittee.

If the rule is being filed for emergency promulgation, please email these items to the attention of Director Marty Garrity, garritym@blr.arkansas.gov, for submission to the Executive Subcommittee.

Please answer each question completely using layman terms.

1. What is the official title of this rule?
Physician Assistants and Clinical Nurse Specialists as Primary Care Providers
2. What is the subject of the proposed rule? 20 CAR 570, 600, 608, 610, 611, 614, 619, 622, 624, 625, 628, 631, 636, 646, 650, 654 (New-CNS), and 655 (New-PA)
3. Is this rule being filed under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☒

If yes, please attach the statement required by Ark. Code Ann. § 25-15-204(c)(1).

If yes, will this emergency rule be promulgated under the permanent provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☐

4. Is this rule being filed for permanent promulgation? Yes ☒ No ☐

If yes, was this rule previously reviewed and approved under the emergency provisions of the Arkansas Administrative Procedure Act? Yes ☐ No ☒

If yes, what was the effective date of the emergency rule? _____

On what date does the emergency rule expire? _____

5. Is this rule required to comply with a *federal* statute, rule, or regulation? Yes ☐ No ☒

If yes, please provide the federal statute, rule, and/or regulation citation.

6. Is this rule required to comply with a *state* statute or rule? Yes ☒ No ☐

If yes, please provide the state statute and/or rule citation.

[Act 482 of 2025](#)

7. Are two (2) rules being repealed in accord with Executive Order 23-02? Yes ☐ No ☒

If yes, please list the rules being repealed.

If no, please explain.

[Exception from the Governor](#)

8. Is this a new rule? Yes ☐ No ☒

Does this repeal an existing rule? Yes ☐ No ☒

If yes, the proposed repeal should be designated by strikethrough. If it is being replaced with a new rule, please attach both the proposed rule to be repealed and the replacement rule.

Is this an amendment to an existing rule? Yes ☒ No ☐

If yes, all changes should be indicated by strikethrough and underline. In addition, please be sure to label the markup copy clearly as the markup.

9. What is the state law that grants the agency its rulemaking authority for the proposed rule, outside of the Arkansas Administrative Procedure Act? Please provide the specific Arkansas Code citation(s), including subsection(s).

[Arkansas Code §§20-76-201, 20-77-107, and 25-10-129](#)

10. Is the proposed rule the result of any recent legislation by the Arkansas General Assembly?
Yes ☒ No ☐

If yes, please provide the year of the act(s) and act number(s).

[Act 482 of 2025](#)

[Acts 303 and 872 of 2023](#)

11. What is the reason for this proposed rule? Why is it necessary?

[The Division of Medical Services \(DMS\) implements provisions of Act 482 of 2025 and provisions of Acts 303 and 872 of 2023 and completes the necessary state plan revisions to align reimbursement rules with current practice authority for physician assistants and clinical nurse specialists. The goal of this rule is to increase the number of providers available to meet the needs of Arkansas Medicaid beneficiaries and increase access to services in rural areas of the state. Physician assistants and clinical nurse specialists will be able to bill independently for services rendered to Medicaid beneficiaries and serve as primary care providers in the Medicaid Primary Care Case Management \(PCCM\) program.](#)

12. Please provide the web address by which the proposed rule can be accessed by the public as provided in Ark. Code Ann. § 25-19-108(b)(1).

ar.gov/dhs-proposed-rules

13. Will a public hearing be held on this proposed rule? Yes ☒ No ☐

If yes, please complete the following:

Date: 05/27/2026

Time: 10:00 am

Place: Zoom

Please be sure to advise Bureau Staff if this information changes for any reason.

14. On what date does the public comment period expire for the permanent promulgation of the rule? Please provide the specific date. 06/08/2026

15. What is the proposed effective date for this rule? 09/01/2026

16. Please attach (1) a copy of the notice required under Ark. Code Ann. § 25-15-204(a)(1) and (2) proof of the publication of that notice.

17. Please attach proof of filing the rule with the Secretary of State, as required by Ark. Code Ann. § 25-15-204(e)(1)(A).

18. Please give the names of persons, groups, or organizations that you anticipate will comment on these rules. Please also provide their position (for or against), if known.

[Arkansas Association of Physician Assistants \(For\)](#)

19. Is the rule expected to be controversial? Yes ☐ No ☒

If yes, please explain.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20-77-107, and 25-10-129. The projected effective date of the rule is August 1, 2026, if approved. There is no fiscal impact.

The Division of Medical Services (DMS) implements Act 482 of 2025 and provisions of Acts 303 and 872 of 2023 and completes the necessary state plan revisions to align reimbursement rules with current practice authority for physician assistants and clinical nurse specialists. Physician assistants and clinical nurse specialists will be able to bill independently for services rendered to Medicaid beneficiaries and serve as primary care providers in the Medicaid Primary Care Case Management program. The rule allows physician assistants and clinical nurse specialists to bill for services rendered to Medicaid beneficiaries at 80% of the physician's rate by implementing existing nurse practitioner payment methodology. The Title XIX maximum is 80% of the physician fee schedule except for EPSDT procedure codes. Medicaid maximum allowable is the same for all EPSDT non-physician providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the clinical nurse specialist and physician. Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of services provided. All rates will be published on the DHS fee schedule website upon approval.

Implementing the practice authority and reimbursement rules requires an Arkansas Medicaid State Plan Amendment (with a proposed retroactive effective date of July 1, 2026) and revision of the following sections of the Arkansas Medicaid Provider Manuals: Section I – General Policy; ARKids First B; Certified Nurse-Midwife; Child Health Services (EPSDT); Counseling and Crisis Services; Federally Qualified Health Center; Home Health; Hospital-Critical Access Hospital-End Stage Renal Disease; Hyperalimentation; Life360 HOMES; Nurse Practitioner; Physicians-Independent Lab-CRNA-Radiation Therapy Center; Rural Health Clinic; Visual Care; Clinical Nurse Specialist (NEW); Physician Assistant (NEW).

The proposed rule is available for review at the Department of Human Services (DHS) Office of Policy and Rules, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules.

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than June 8, 2026. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing will be held online by remote access. Public comments may be submitted at the hearing. The details for attending the online public hearing appear at ar.gov/dhspublichearings.

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color or national origin. 4502292178

Elizabeth Pitman, Director
Division of Medical Services

From: [Legal Ads](#)
To: [Kate Chagnon](#)
Subject: Re: Full Run Ad (Rule 335)
Date: Friday, May 8, 2026 11:39:45 AM
Attachments: [image001.png](#)

CAUTION: External Email

Scheduled for Sun 5/10, Mon 5/11, and Tues 5/12. Thank you.

Gregg Sterne, Legal Advertising
Arkansas Democrat-Gazette
legalads@arkansasonline.com

From: "Kate Chagnon" <Kate.Chagnon@dhs.arkansas.gov>
To: "legalads" <legalads@arkansasonline.com>
Cc: "Mac Golden" <Mac.E.Golden@dhs.arkansas.gov>, "Jack Tiner" <jack.tiner@dhs.arkansas.gov>, "Lakeya Gipson" <Lakeya.Gipson@dhs.arkansas.gov>, "Elaine Stafford" <elaine.stafford@dhs.arkansas.gov>
Sent: Friday, May 8, 2026 11:31:09 AM
Subject: Full Run Ad (Rule 335)

Hi Gregg,

Please reply to this email using REPLY ALL to confirm receipt and processing of this request.

Please run the attached public notice in the *Arkansas Democrat-Gazette* on **Sunday 5/10/26, Monday 5/11/26, and Tuesday 5/12/26.**

I am aware that the print version will only be provided to all counties on Sundays.

Invoice to: **AR Dept of Human Services**
OPR, ATTN: Lakeya Gipson
P.O. Box 1437, Slot S295
Little Rock, AR 72203-8068

From: [Kate Chagnon](#)
To: ["ArkansasRegister@sos.arkansas.gov"](mailto:ArkansasRegister@sos.arkansas.gov)
Cc: [Mac Golden](#); [Jack Tiner](#); [Lakeya Gipson](#); [JAMIE EWING](#)
Subject: DHS/DMS—Proposed Filing—Physician Assistants and Clinical Nurse Specialists as Primary Care Providers (Rule 335)
Date: Friday, May 8, 2026 6:37:00 PM
Attachments: [Arkansas Register Proposed Filing_R335_PA and CNS as PCP.pdf](#)
[image001.png](#)

Hello,

Please find attached a proposed filing for Physician Assistants and Clinical Nurse Specialists as Primary Care Providers (Rule 335).

The public notice will be published in the *Arkansas Democrat-Gazette* on 5/10/26, 5/11/26, and 5/12/26.

The public comment period ends 6/8/26.

I look forward to confirmation of your receipt.

Thank you!



Kate Chagnon

Rules & Regulations Coordinator
Arkansas Department of Human Services
Office of Policy and Rules

P: 501.371.1316

kate.chagnon@dhs.arkansas.gov

humanservices.arkansas.gov

Privacy Notice: This email may contain confidential information protected by state/federal laws. If you are not the intended recipient, please let the sender know, and delete the message/attachment(s) from your system.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services

BOARD/COMMISSION _____

PERSON COMPLETING THIS STATEMENT Andy Morgan

TELEPHONE NO. (501) 534-4125 **EMAIL** andy.morgan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Physician Assistants and Clinical Nurse Specialists as Primary Care Providers

1. Does this proposed, amended, or repealed rule have a financial impact?
Yes ☐ No ☒
2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule?
Yes ☒ No ☐
3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

If no, please explain:

(a) how the additional benefits of the more costly rule justify its additional cost;

(b) the reason for adoption of the more costly rule;

(c) whether the reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

(d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

4. If the purpose of this rule is to implement a *federal* rule or regulation, please state the following:
 - (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year

General Revenue_____

Federal Funds_____

Cash Funds_____

Special Revenue_____

Other (Identify)_____

Total_____

Next Fiscal Year

General Revenue_____

Federal Funds_____

Cash Funds_____

Special Revenue_____

Other (Identify)_____

Total_____

(b) What is the additional cost of the state rule?

Current Fiscal Year

General Revenue 0_____

Federal Funds_____

Cash Funds_____

Special Revenue_____

Other (Identify)_____

Total \$ 0.00_____

Next Fiscal Year

General Revenue 0_____

Federal Funds_____

Cash Funds_____

Special Revenue_____

Other (Identify)_____

Total \$ 0.00_____

5. What is the total estimated cost by fiscal year to any private individual, private entity, or private business subject to the proposed, amended, or repealed rule? Please identify those subject to the rule, and explain how they are affected.

Current Fiscal Year

\$ 0.00_____

Next Fiscal Year

\$ 0.00_____

6. What is the total estimated cost by fiscal year to a state, county, or municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year

\$ 0.00_____

Next Fiscal Year

\$ 0.00_____

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If yes, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
 - (a) justifies the agency's need for the proposed rule; and
 - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
 - (a) the rule is achieving the statutory objectives;
 - (b) the benefits of the rule continue to justify its costs; and
 - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Statement of Necessity and Rule Summary

Physician Assistants and Clinical Nurse Specialists as Primary Care Providers

Statement of Necessity

The Division of Medical Services (DMS) implements provisions of Act 482 of 2025 and provisions of Acts 303 and 872 of 2023 and completes the necessary state plan revisions to align reimbursement rules with current practice authority for physician assistants and clinical nurse specialists. The goal of this rule is to increase the number of providers available to meet the needs of Arkansas Medicaid beneficiaries and increase access to services in rural areas of the state. Physician assistants and clinical nurse specialists will be able to bill independently for services rendered to Medicaid beneficiaries and serve as primary care providers in the Medicaid Primary Care Case Management (PCCM) program.

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- Rural Health Clinic (20 CAR 646)
- Visual Care (20 CAR 650)
- Clinical Nurse Specialist (20 CAR 654 – NEW)
- Physician Assistant (20 CAR 655 – NEW)

TOC required

101.000 Provider Manuals**4-1-1611-1-26**

Provider manuals contain the policies and procedures of the Arkansas Medicaid Program. These policies and procedures are generally based on federal and state laws and federal regulations. Medicaid provider manual policy and procedures, and changes thereto, are promulgated as required by the state's Administrative Procedure Act.

When fully utilized, each program manual is an effective tool for the provider. It provides information about the Medicaid Program, covered and non-covered services, billing procedures and detailed instructions for completing ~~paper~~ claims.

Obtain provider manuals from the ~~Arkansas Medicaid~~ **DMS website**.
(<https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx>).

101.100 Provider Manual Organization**4-1-1611-1-26**

The manuals are organized as follows:

- A. Section I – general information
- B. Section II – program policy and program-specific billing information, including special billing
- C. Section III – generic billing information
- D. Section IV – glossary
- E. Section V – forms and contact information
- F. Notices of Rule Making
- G. Official Notices
- H. Remittance Advice (RA) messages ~~(RAs)~~

Sections I, III, IV and V are the same in each manual; only Section II is program- and provider-specific. Separate hyperlinks to other policy-related notifications (items F, G and H above) address either specific providers/programs or all providers. Providers should review both.

The manuals are divided into numbered sections with a heading and a revision date, such as "101.000 Provider Manuals 4-1-061-1-20". Text that appears underlined and blue indicates a hyperlink to the information being referenced, and it may be viewed or printed. The paper version contains the same underlined text, though not in blue, so paper users must locate the "linked" information.

101.200 Updates**8-1-1211-1-26**

Provider manuals are amended ("updated") in accordance with new, repealed or revised federal and state legislative and legal clarifications. Changes and clarifications in DMS medical policy, new administrative or billing procedures and numerous other requirements are issued and implemented when warranted. These changes and clarifications are released to the provider in the form of a manual update, a notice of rule making, an official notice or a remittance advice (RA) message.

Provider manuals are updated automatically on the [Arkansas Medicaid DMS](#) website. Providers are notified via e-mail when an applicable manual update transmittal is issued. Providers must give Provider Enrollment a valid, current e-mail address to receive such e-mail notification, and report changes as needed. Only revised sections are issued in manual updates along with an update transmittal memorandum-letter to detail changes. All policy changes including manual updates, notices of rule making, official notices and RA messages are posted weekly on What's new for Arkansas Medicaid providers at <https://medicaid.mmis.arkansas.gov/Provider/newprov.aspx>. Bookmark this page and review often for the latest provider information.

Policy and procedure changes are highlighted in the electronic media to help providers quickly review changes. Provider manual update transmittals are assigned sequential identification numbers, e.g., Update Transmittal MANUAL-1-11. The transmittal memo-letter identifies any new sections being added and the sections being replaced, deleted, or amended. It provides brief explanations of the revisions. Provider manual update transmittal memos-letters are recorded on the update log following each section of the manual.

For persons maintaining a printed provider manual, the updated manual sections should be manually filed in the provider manual, and the outdated sections should be crossed out or removed, as appropriate. The transmittal memo-letter effective date should be entered on the update log opposite the appropriate update transmittal number. Transmittal memos-letters should be filed immediately following the update log in descending numerical order by transmittal number. Immediately following the transmittal memos-letters should be the notices of rule making, then official notices, both of which are numbered sequentially and should be filed with the most recent first. The RA messages will follow the notices of rule making and official notices, with the most recent filed first.

101.300 Obtaining Provider Manuals

8-1-2411-1-
26

All provider manuals, manual updates, notices of rule making, official notices, and RA messages are available to for downloading or print, without charge, from the Arkansas Medicaid website DMS website. Instructions to maintain a printed provider manual can be found in Section 101.200.

~~Enrolled providers may purchase extra paper copies of a manual through the fiscal agent. See information below regarding purchasing copies. Persons, entities and organizations that are not enrolled providers may purchase a paper copy of a provider manual through the fiscal agent.~~

~~The cost for a printed copy of an Arkansas Medicaid provider manual is \$125.00.~~

~~Send orders for printed manuals to the Arkansas Medicaid Fiscal Agent, Information Library Unit. Include with your order a check made to the Fiscal Agent for the appropriate amount. View or print the manual order contact information.~~

110.400 Rate Review ProcessReserved

5-1-1411-1-
26

A provider may request reconsideration of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). The request must be received within twenty (20) calendar days following the application of a rate related policy or procedure, or the notice to the provider of its rate. Upon receipt of the request for review, the DMS Director will give the provider the opportunity for a conference to fully explain the factors involved in the program's rate related policy or procedure. Following review of the matter, the DMS Director will notify the provider of the action to be taken by DMS within twenty (20) calendar days of receipt of the request for review or the date of the program or provider conference.

The provider may request review of the matter by a standing rate review panel if the decision of the DMS Director is unsatisfactory to the provider. The rate review panel will be established by the DMS Director and will include one (1) Department of Human Services staff member, one (1)

representative of a relevant provider association, and one (1) member of Department of Human Services (DHS) executive leadership staff (other than the DMS Director), who will serve as chairman.

The provider's request for review by a rate review panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the DMS Director. The rate review panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of the request for a review. Questions will be heard by the panel and a recommendation will be submitted to the Medicaid Director. The Medicaid Director may adopt, modify, decline, or remand (send back) the recommendation of the Rate Review Panel.

111.000 DMS and Fiscal Agent Office Hours

9-15-0911-
1-26

A Provider Assistance Center is available for provider billing and reimbursement questions 8:00 a.m. until 5:00 p.m., Monday through Friday, with the exception of state and official holidays.

[View or print the Provider Assistance Center contact information.](#)

The Division of Medical Services is available to answer provider questions regarding service coverage not directly addressed within this provider manual 8:00 a.m. until ~~54:030~~ p.m., Monday through Friday, with the exception of state and official holidays. [View or print the Division of Medical Services contact information.](#)

~~142.900 Principal Accountable Providers (PAPs)~~

7-1-16

~~An Arkansas Medicaid-enrolled and qualified provider who is licensed to diagnose and treat a beneficiary may be designated as a Principal Accountable Provider (PAP) within the Episodes of Care payment improvement initiative. Individual providers may be designated as a PAP only by a promulgated episode.~~

170.100 Introduction

8-1-1811-1-
26

Arkansas Medicaid's Primary Care Case Management (PCCM) Program operates statewide under the authority of the Medicaid State Plan.

- A. Most Medicaid beneficiaries and all ARKids First-B participants must enroll with a primary care ~~physician-provider~~ (PCP), also known as a primary care case manager (PCCM).
PCPs:
 1. ~~PCPs~~ provide primary care services and health education_;
 2. ~~PCPs~~ make referrals for medically necessary specialty ~~physician's-provider~~ services, hospital care_; and other services_;
 3. ~~PCPs~~ assist their enrollees with locating medical services_;
 4. ~~PCPs~~ coordinate and monitor their enrollees' prescribed medical and rehabilitation services.
- B. Medicaid enrollees may only receive services ~~only~~ from their PCP unless their PCP refers them to another provider, or unless they access a service that does not require a PCP referral.
- C. If a beneficiary does not have a primary care provider, Arkansas Medicaid will allow up to four (4) visits per state fiscal year without a Primary Care ~~Physician-Provider~~ (PCP) referral to a hospital affiliated Walk-in Clinic or Emergent Clinic.
- D. These visits apply to all related benefit limits.

171.000 Primary Care ~~Physician-Provider~~ Participation**171.100 PCP-Qualified Physicians, and Advanced Practice Nurse Practitioners, ~~Physician Assistants, and Certified Nurse Specialists~~** **4-1-2411-1-26**

- A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is:
 - 1. Family practice;
 - 2. General practice;
 - 3. Internal medicine;
 - 4. Pediatrics and adolescent medicine; or
 - 5. Obstetrics and gynecology.
- B. Obstetricians and gynecologists may choose ~~whether~~ to be enrolled as PCPs.
- C. ~~Physicians-Providers~~ with multiple specialties may ~~elect-choose~~ to enroll as PCPs, if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.
- D. All other PCP-qualified physicians must enroll as PCPs.
- E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.
- F. Clinical Nurse Specialists may choose to enroll as PCPs.
- G. Certified Nurse-Midwives may choose to enroll as PCPs.
- H. Physician Assistants authorized by a supervising physician may choose to enroll as PCPs. When initially enrolling with Medicaid to be recognized as a PCP, a physician assistant shall provide written authorization that is signed and dated by his or her supervising physician. In addition, the supervising physician must be actively enrolled in Arkansas Medicaid.

171.110 Exclusions **4-1-2411-1-26**

- A. ~~Physicians-Providers~~ whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.
- B. Physician group practices may not be PCPs.
- ~~C. Rural Health Clinics (RHCs) may not be PCPs, but PCP-qualified physicians affiliated with RHCs must be PCPs.~~
- ~~D. Physicians who certify in writing that they are employed.~~

171.120 Hospital Admitting Privileges Requirement **7-1-0511-1-26**

- A. Only ~~physicians-providers~~ with hospital admitting privileges may be PCPs.
- B. The state may waive this requirement to help ensure adequate access to services: when:
 - 1. On the primary care case manager (PCCM) contract, a providerphysician may name another physician-provider who has hospital admitting privileges and with whom he or she has an agreement by which theyto handle hospital admissions on the primary care case manager (PCCM) contract.

2. A copy of the ~~physician provider~~s' agreement must be submitted with the PCCM contract.

171.130 EPSDT Agreement Requirement

4-1-2411-1-
26

- A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) program.
- B. Internists, obstetricians, gynecologists, and ~~physicians-providers~~ who customarily carry a caseload of patients who are twenty-one (21) years of age or older are not required to furnish EPSDT screens. However, should these providers opt to participate in the EPSDT program, they must sign the EPSDT agreements.
- ~~1. Their participation in the Child Health Services (EPSDT) program is optional.~~
- ~~2. They must, however, sign Child Health Services (EPSDT) agreements if they elect to be screening providers.~~

171.160 PCP In Sstate and Trade-Area Restriction

7-1-0511-1-
26

~~With the following exceptions,~~ PCPs must practice in Arkansas. except when the following conditions apply:

- A. PCP-qualified ~~providers~~physicians in the trade-area cities (Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee, and Texarkana, Texas), may be PCPs.
- B. ~~To ensure adequate access to services,~~ the state may waive the trade-area city rule for border-state ~~physicians-providers~~ who are not in trade-area cities to ensure adequate access to services.

171.200 PCCM Enrollee and/ Caseload Management

171.210 ConnectCare Caseload Maximum and PCP Caseload Limits

10-8-1011-
1-26

- A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500.:
1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
 2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create ~~a~~ hardship for them, their patients, ~~and/~~or the community they serve.
- B. The state will not require ~~any~~ PCP to accept a caseload greater than the PCP's requested caseload maximum.
- C. ~~At any time, a~~ PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by completing and submitting a written request to the Provider Enrollment Unit, or on-line through the Medicaid website (<https://medicaid.mmis.arkansas.gov/>), Provider Enrollment Information, and Access to the an electronic DMS-2608, PCP Agreement form. The completed form should be uploaded to the Health Care Provider Portal (for help, see the job aid **How to Upload Documents**).
- D. To request an increase in a PCP caseload above the default maximum, the PCP must submit ~~a written request~~ to the Provider Enrollment Unit an electronic DMS-2608, PCP

Agreement form along with a signed letter explaining the necessity by uploading to the Health Care Provider Portal. (See the job aid **How to Upload Documents** if needed.) The State must approve requests that exceed the maximum caseload. View or print Provider Enrollment Unit contact information.

- E. ~~Prior to making the request for an increase of a caseload that is already at the default maximum,~~ PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload prior to making a request for an increase of their caseload. To do so, PCPs may use the Arkansas Medicaid Information Interchange (AMII) web portal ~~their DMS caseload report in MMIS~~. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:
1. Contact the patient in writing at least thirty (30) days in advance of the effective date of the termination to give the patient the option to remain an active patient by making a visit to the PCP ~~to remain an active patient~~. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of thirty (30) calendar days.
 2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the thirty (30) calendar day ~~notification~~ process of inactive patients.
 3. The notice must state ~~that the~~ inactive enrollee has thirty (30) calendar days in which to enroll with a different PCP.
 4. The PCP must forward a copy of the notice to the inactive enrollee, ~~and to the local DHS office in the enrollee's county of residence~~ and their Provider Relations Representative and ConnectCare.

171.220 **Illegal Discrimination**

711-1-2605

- A. A PCP may not reject a potential enrollee on the basis that they are a Medicaid beneficiary if the PCP has openings on his or her caseload, and may not discriminate against a beneficiary because of the individual's age, sex, race, national origin, or type of illness or condition.
- B. Rejecting a potential enrollee based on the individual's age or sex does not constitute unlawful discrimination if the physician-provider customarily sees only patients of one sex, and/or a particular age range, or both. For instance:
1. An obstetrician/gynecologist doesn't treat males, so he or she is not expected to enroll males.
 2. A pediatrician specializing in adolescent medicine may only see patients in a particular age range, such as twelve (12) through eighteen (18) years old.
- C. PCPs may specify the minimum and maximum ages of Medicaid and ARKids First-B enrollees they will accept.

171.230 **Primary Care Case Management Fee**

4-4-2311-1-26

- A. In addition to reimbursing PCPs on a fee for service basis for physician-provider services, Arkansas Medicaid pays them a monthly case management fee for each enrollee on their caseloads.
- B. The amount due for each month is determined by multiplying the established case management fee by the number of enrollees on the PCP's caseload.
1. Medicaid pays case management fees quarterly.

2. The accompanying Medicaid Remittance and Status Report (RA) itemizes the payments, ~~and~~ lists the number of enrollees, and identifies each enrollee's enrollment months.
 3. Enrollees are listed alphabetically by name, with their Medicaid identification numbers and addresses ~~also~~ displayed.
- C. PCP case management fees are paid according to the PCP's direction. The PCP may choose to have the case management fee paid to his or her individual provider ID number or to the group provider ID number with whom the PCP is affiliated.
 - D. If the PCP's case management fees are paid to a group and the PCP changes his or her affiliation, the PCP must submit a new PCP Agreement Form to Provider Enrollment within thirty (30) calendar days of changing affiliation. The PCP must ~~also~~ notify the beneficiaries on his or her caseload of the change.
 - E. If ~~athe~~ PCP fails to submit a new PCP Agreement Form, the case management fees will pay to the provider of record until a new PCP Agreement Form is received by Provider Enrollment.
 - F. If a Group Affiliation Form is received by Provider Enrollment to disassociate a PCP from a group but the PCP Agreement Form is not received, the case management fees will be paid to the individual PCP's provider ID number.
 - G. If ~~athe~~ PCP's case management fees were paid to a group in which the PCP is no longer affiliated, it is the responsibility of that group to reimburse Medicaid the fees they were not entitled to receive.
 - H. **No case management fees will be back paid to a PCP who has failed to follow the process described in Paragraph D of this Section.**
 - I. ~~-~~Case management fees will be reconciled at least quarterly, and may be reconciled at any time determined necessary to resolve immediate issues.

171.400 PCP Referrals

4-1-1811-1-
26

- A. Referrals may be only for medically necessary services, supplies or equipment.
- B. The PCP must give eEnrollees free choice by naming two or more providers of the same type or specialty when making referrals.
- C. PCPs are not required to make retroactive referrals.
- D. ~~Since-Because~~ PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.
- E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies ~~somewhat~~ in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)
- F. ~~There is no limit on the~~ number of times a referral may be renewed is not limited, but renewals must be medically necessary and at least every six (6) months (with exceptions as noted in part E, above).
- G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

- H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.
- I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

171.410 PCCM Referrals and Documentation

7-1-0511-1-
26

- A. Medicaid provides an optional referral form, ~~form~~-DMS-2610, to facilitate referrals. [View or print form DMS-2610.](#)
 - 1. Additionally, PCP referrals may be oral, by note, or by letter but must contain all components of the DMS-2610 form.
 - 2. Referrals may be faxed.
- B. Regardless of ~~the means by which~~how the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.
 - 1. Medicaid also requires documentation of the referral in the patient's chart by the provider to whom the referral is made.
 - 2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

171.500 Primary Care Case Management Activities and Services

7-1-0511-1-
26

A ConnectCare PCP is also known as a primary care case manager (PCCM). He or she provides primary care ~~physician-provider~~ services as well as these additional services:

- A. Health education;
- B. Assessing each enrollee's medical condition, initiating and recommending treatment or therapy when needed;
- C. Initiating referrals to specialty physicians and for hospital care and other medically necessary services;
- D. Assisting with locating ~~needed~~medical services needed;
- E. Coordinating, ~~with other professionals,~~prescribed medical and rehabilitation services with other professionals;
- F. Monitoring enrollees' prescribed medical and rehabilitation services.

171.510 Access Requirements for PCPs

7-1-0511-1-
26

- A. A PCP must have hours of operation that are reasonable and adequate to serve ~~all of~~his or her patients.
 - 1. The PCP's office must be open to Medicaid enrollees during the same hours and for the same number of hours as it is for self-pay and insured patients.
 - 2. ConnectCare enrollees must have the same access to emergency and non-emergency medical services as private pay and insured ~~persons-people have to emergency and non-emergency medical services.~~
- B. A PCP must make available twenty-four (24)-hours, seven (7) days per week telephone access to a live voice (an employee of the primary care ~~physician-provider~~ or an answering

service) or to an answering machine that will immediately page an on-call medical professional. The on-call professional will:

1. Provide information and instructions for treating emergency and non-emergency conditions,
 2. Make appropriate referrals for non-emergency services, and
 3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.
- C. ~~A PCP must respond~~**Response** to after-hours calls regarding non-emergencies ~~must be~~ within ~~thirty~~ (30) minutes.
1. PCPs must make the after-hours telephone number as widely available as possible to their patients.
 2. When ~~employing-using~~ 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.
- D. PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.
- E. ~~As regards~~**Regarding** access to services, PCPs are required to provide the same level of service for their ConnectCare enrollees as they provide for their insured and privately-~~payid~~ patients.
- F. ~~Physicians-Providers~~ and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations, and any other pertinent information to the PCP ~~for inclusion to~~ **include** in the patient's medical record.
- G. A PCP may not refer ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

171.601 PCP Substitutes; General Requirements

4-1-0711-1-
26

- A. ~~Physicians-Provider~~ substituting for PCPs are not required to be PCPs themselves.
- B. In addition to the rules that apply to physician substitutes (found in the Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual), ~~physicians~~ **providers** substituting for PCPs are subject to the following regulations:
1. The PCP and the substitute must document the substitution in each enrollee's record(s) as a referral and include the reason for the substitution.
 2. The substitute ~~physician-provider~~ must furnish the PCP's name and provider identification number to any other provider to whom he or she refers the patient.

171.610 PCP Substitutes; Rural Health Clinics and Physician Group Practices

7-1-0511-1-
26

When a PCP is affiliated with a rural health clinic (RHC) or is a member of a ~~physician-provider~~ group, other ~~physicians-providers~~ affiliated with the RHC or other members of the ~~physician provider~~ group may substitute for the PCP when he or she is unavailable.

- A. Acceptable reasons for a PCP ~~not~~ to be **un**available include (but are not limited to):
1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.

2. The PCP is in surgery or attending a delivery.
 3. An unusual number of patients need services outside the PCP's normal working hours.
 4. The PCP is ill, ~~or~~ on vacation, or other leave of absence.
- B. Habitual over-scheduling of patients or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

171.620 PCP Substitutes; ~~Individual Practitioners~~

7-1-0511-1-
26

A PCP that is an individual practitioner must designate a substitute physician-provider to take calls, see patients, and make appropriate referrals when the PCP is unavailable.

- A. Acceptable reasons for a PCP ~~not~~ to be unavailable include (but are not limited to):
1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
 2. The PCP is in surgery or attending a delivery.
 3. An unusual number of patients need services outside the PCP's normal working hours.
 4. The PCP is ill, ~~or~~ on vacation, or other leave of absence.
- B. Habitual over-scheduling or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

~~171.630 Advanced Practice Registered Nurses and Physician Assistants in Rural Health Clinics (RHCs)~~

7-1-22

~~Advanced-practice registered nurses (APRN) may function as Primary Care Providers at the performing provider level.~~

~~Licensed registered nurse practitioners (RNP) or licensed physician assistants (PA) employed by a Medicaid-enrolled rural health clinic (RHC) provider may not function as Primary Care Provider (PCP) substitutes, but they may provide primary care for a PCP's enrollees, with certain restrictions.~~

- ~~A. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished~~
- ~~1. To the PCP's client enrollees~~
 - ~~2. By registered nurse practitioners and physician assistants~~
 - ~~3. In or on behalf of the RHC~~
- ~~B. Registered nurse practitioners and physician assistants (PA) may not make referrals for medical services except for pharmacy services per established protocol.~~
- ~~C. The PCP must maintain a supervisory relationship with the registered nurse practitioners and physician assistants (PA).~~

172.300 Automated PCP Enrollment Verification

7-1-0511-1-
26

- A. An electronic Medicaid eligibility verification response includes PCP name and telephone number, and the beginning date of the current enrollment period.

1. If no current PCP is displayed on the eligibility response, the individual is not enrolled with a PCP.
 2. Beneficiaries with no PCP should be referred to the ConnectCare Helpline for information and assistance. [View or print the ConnectCare Helpline contact information.](#)
- B. Medicaid beneficiaries and ARKids First-B participants—regardless of whether ~~or not~~ they are enrolled with a PCP—are responsible for all charges for services they receive without obtaining required referrals.

173.000 PCCM Selection, Enrollment and Transfer

7-1-0511-1-
26

- A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP ~~in order~~ to obtain a PCP referral for medical services.
1. ~~All n~~Newly eligible individuals are given opportunities to enroll.
 2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders ~~from ConnectCare~~ of the advantages of PCP enrollment from ConnectCare.
- B. An individual must select a PCP that is located near his or her residence.
1. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence, or a county that adjoins a county adjacent to the county of residence.
 2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection and Enrollment at Local County DHS Offices

9-15-0911-
1-26

- A. Medicaid applicants receive ~~from DHS county office staff~~, a description and explanation of ConnectCare from DHS county office staff.
1. By means of a Primary Care ~~Physician-Provider~~ Selection and Change form (DMS-2609 or DCO-2609,) an applicant indicates the first, second, and third choice for PCPs of each family member included in the Medicaid case.
 - ~~2. Individuals applying for ARKids First A and B indicate their PCP preferences on the mail in application (form DCO 995).~~
 - ~~32.~~ Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.
- ~~B. When eligibility is determined, a DHS worker uses a web-based program or a telephonic voice response system to enroll the beneficiary with a PCP, beginning with each beneficiary/participant's first choice.~~
- ~~1. If the first choice has a full caseload, the worker tries the second choice and so on.~~
 - ~~2. The county office forwards confirmation of PCP enrollment to each new enrollee.~~

173.200 PCP Selection and Enrollment at PCP Offices and Clinics

10-8-1011-
1-26

~~Physician and single-entity~~ PCP Providers may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS.)

- A. Enrollees must document their PCP choice on a Primary Care ~~Physician-Provider~~ Selection and Change form (DMS-2609 or DCO-2609.)

1. The form must be completed, dated, and signed by the enrollee.
 2. The enrollee may request and receive a copy of the form.
 3. The PCP office must retain a copy of the form in the enrollee's file.
- B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. [View or print Voice Response System \(VRS\) contact information.](#)
- C. When a PCP wants to add a new enrollee, but the PCP's Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:
1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the [Medicaid website https://medicaid.mmis.arkansas.gov/ Provider Enrollment Information](https://medicaid.mmis.arkansas.gov/Provider-Enrollment-Information), Access to the [Provider Information Portal](#).
 2. ~~Prior to making the request for an increase of a caseload that is already at maximum, the PCP is encouraged to review their caseload using the AMII (Arkansas Medicaid Information Interchange) web portal for inactive patients, to determine if those patients should be removed from their caseload.~~ An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. [View or print Provider Relations Representative contact information.](#) ~~Prior to making the request for the increase of a caseload that is already at maximum, the PCP is encouraged to review his or her caseload using the DMS caseload report for inactive patients in MMIS to determine whether those patients should be removed. PCPs must follow the guidelines within Section 171.210 to notify patients regarding their removal from the PCP's caseload.~~

173.300 PCP Selection and Enrollment Through the ConnectCare HelpLine 7-1-0511-1-26

- A. PCP enrollment through the ConnectCare HelpLine is recommended.
- B. ConnectCare HelpLine is operated by Medicaid Outreach and Education for ConnectCare.
1. ConnectCare HelpLine staff ~~is~~are available for PCP enrollments and transfers ~~24 hours a day, Monday through Thursday, and Friday until midnight~~8:00 a.m. – 5:00 p.m. Monday through Friday.
 2. The HelpLine number (1-800-275-1131) is prominently displayed in ConnectCare publications, frequently in more than one place. [View or print ConnectCare contact information.](#)
 3. HelpLine staff members help Medicaid beneficiaries and ARKids First-B participants locate PCPs in their area.
 4. HelpLine staff can help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400 PCP Selection and Enrollment at Participating Hospitals 7-1-0511-1-26

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

- A. Enrollment is by means of a Primary Care ~~Physician-Provider~~ Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).
1. Hospital personnel enter the PCP selection via the VRS.
 2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.

3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within twenty-four (24) hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.
- B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.
- C. The enrollee may request and receive a copy of the completed selection form.
- D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.500 PCP Selection for Supplemental Security Income (SSI) Beneficiaries **7-1-0511-1-26**

Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

- A. When an SSI beneficiary's Medicaid eligibility determination is made, the Arkansas Medicaid fiscal agent generates a letter describing ConnectCare.
 1. It includes instructions for selecting and enrolling with a PCP.
 2. A Primary Care Physician-Provider Selection and Change form (DCO-2609) is enclosed in the mailing.
- B. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid beneficiaries.

173.600 Transferring PCP Enrollment

173.610 PCP Transfers by Enrollee Request **9-15-0911-1-26**

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

- A. Enrollees are encouraged to use the ConnectCare HelpLine when transferring their enrollment from one PCP to another. Enrollees may change their PCP by calling ConnectCare at 1-800-275-1311 or by completing the PCP Change Request form online at www.seeyourdoc.org.
- B. Enrollees may also change their PCP at the local DHS county office in the enrollee's county of residence, but the enrollee or the enrollee's parent or guardian must request the transfer in writing by means of an Arkansas Medicaid Primary Care Physician-Provider Selection and Change form (DMS-2609 or DCO-2609).

173.620 PCP Transfers by PCP Request **9-15-0911-1-26**

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 two (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, t~~The PCP must give the enrollee written notice to transfer his or her enrollment to another PCP at least thirty (30) days in advance of the effective date of the termination.
1. The notice must state that the enrollee has thirty (30) days ~~in which~~ to enroll with a different PCP.
 2. The PCP must forward a copy of the notice to the enrollee and ~~to the local DHS office in the enrollee's county of residence, and to their Provider Relations Representative, and ConnectCare.~~
- C. The PCP continues as the enrollee's primary care ~~physician-provider~~ during the thirty (30) days or until the individual transfers to another PCP, whichever comes first.

173.630 PCP Enrollment Transfers Initiated by the State

7-1-0511-1-
26

The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers ~~come about~~happen because DMS, in exercising its regulatory function, ~~sometimes~~ must sometimes sanction, suspend, or terminate a provider.

- A. For instance, a provider may lose his or her PCP or Medicaid contract for:
1. Failure to meet PCP or Medicaid contractual obligations;
 2. Proven and consistent excessive utilization;
 3. Unnecessarily limited utilization of medically necessary services.
- B. When the State terminates a PCP's contract, ~~DMHS~~ Division of Medical Services (DMS) contacts the PCP's enrollees with instructions for transferring their PCP enrollment.

Instructions must include beneficiary access to a listing of all PCPs who have an open panel and are accepting Medicaid patients within the enrollee's geographical area.

180.000 ~~EPISODES OF CARE~~

10-1-20

~~The Episodes of Care program will gradually conclude over the two (2) state fiscal years 2020 and 2021. State fiscal year 2020 will be the final payment reporting period year for each episode's performance period. In State fiscal year 2021, the final reconciliation report will be generated. The reconciliation report period allows Principal Accountable Providers the opportunity to improve their gain share/risk share or incentive position.~~

181.000 ~~Incentives to Improve Care Quality, Efficiency and Economy~~

7-1-16

~~A. Definitions~~

- ~~1. An "episode" refers to a defined bundle of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.~~
- ~~2. An "episode type" is defined by a diagnosis, health care intervention or condition during a specific timeframe (or performance period).~~
- ~~3. "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.~~
- ~~4. A "valid episode" is defined as any episode that meets criteria for inclusion in a calculation of cost and quality measures for which a PAP is accountable during a performance period.~~
- ~~5. An "invalid (excluded) episode" refers to an episode in which the services or the patient do not meet standard criteria for inclusion set by the definition of each~~

episode type. (Refer to the Episodes of Care Medicaid Manual for episode-specific criteria.)

6. An “incentive” can either be positive (gain share) or negative (risk share).

- B. Medicaid has established a payment improvement initiative (“payment improvement program”) to incentivize improved care quality, efficiency and economy. The program uses Medicaid paid claims data to evaluate the quality, efficiency and economy of care delivered in the course of the episode and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific Episodes of Care.**
- C. The payment improvement program is separate from, and does not alter, current methods for reimbursement.
- D. The payment improvement program promotes efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and when provider referrals are necessary, encouraging referrals to efficient and economic providers who furnish high-quality care.
- E. All medical assistance provided in the delivery of care for an episode may be included in the determination of an incentive under the payment improvement program.
- F. Incentives may be positive (gain share) or negative (risk share). Incentives are calculated and made retrospectively, after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentives are based on the aggregate of valid, paid claims across a provider’s episodes and are not relatable to any individual provider claim for payment.
- G. Medicaid establishes episode definitions, levels of incentives and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical practices information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from quality measurement organizations, peer-reviewed medical literature or any combination thereof.
- H. Principal Accountable Providers
 - The Principal Accountable Provider(s) (PAPs) for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAPs after an episode is complete using algorithms described in the episode definition.
- I. Incentives
 - For each PAP for each applicable episode type:
 - 1. Performance will be aggregated and assessed over a specified period of time (“performance period”). For each PAP, the average reimbursement across all valid episodes completed during the performance period will be calculated, based on the set of services included in the episode definition. **Please refer to the Episodes of Care Medicaid Manual for information about specific Episodes of Care.**
 - 2. Some episodes may be excluded based on clinical factors derived from paid claims. Other exclusions may be determined from coverage factors for each individual patient.
 - 3. Reimbursement for some episodes may be adjusted as described in the definition of each episode. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds which are established by Medicaid in consultation with providers.

4. If a PAP's average adjusted episode reimbursement is lower than the commendable threshold and the PAP has met the quality measures established by Medicaid for each episode type, the PAP is eligible for gain share and Medicaid will make a positive incentive to the PAP. This will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive an incentive calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.
5. If the average adjusted episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative (risk share) incentive. This incentive to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

J. Principles for Determining "Thresholds"

1. The threshold process aims to incentivize high quality clinical care delivered efficiently and to consider several factors including the potential to improve patient access, the impact on provider economics and the level and type of practice pattern changes required for performance improvement.
2. The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system wide variance from widely accepted clinical standards.
3. The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.
4. The gain sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.
5. The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

K. Outlier Patient Exclusions

- Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high or low cost episodes and/or comorbid conditions so that one or a few cases do not misrepresent a provider's overall performance across the provider's broader patient population.

L. Provider Level Adjustments

1. Incentives for each PAP take into account provider level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume or any combination thereof.
2. Stop-loss protection: Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all Episodes of Care adjustments made during any

calendar year shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements received by the provider during that calendar year.

3. Temporary stop-loss provisions may apply when necessary to ensure access to care.
4. Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive (gain-share) and negative (risk-share) incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.
5. Each episode has a designated minimum case volume that must be reached in order for the PAP to be eligible for incentives. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive (gain-share) or negative (risk-share) incentives for that episode type.

M. Quality Measures

1. For each episode type, there is a set of quality measures "to pass" and/or a set of quality measures "to track." These quality measures are based on paid claims data or based on additional data when specified by Medicaid and which PAPs are required to report through the Advanced Health Information Network (AHIN) provider portal.
2. To qualify for positive (gain-share) incentives, PAPs must report required data and meet specific quality measures "to pass."
3. Providers who do not report data or who do not meet minimum quality measures may still incur negative (risk-share) incentives if their average adjusted episode reimbursement exceeds the acceptable threshold.

- N. Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

TOC required**101.000 Provider Manuals****11-1-26**

Provider manuals contain the policies and procedures of the Arkansas Medicaid Program. These policies and procedures are generally based on federal and state laws and federal regulations. Medicaid provider manual policy and procedures, and changes thereto, are promulgated as required by the state's Administrative Procedure Act.

When fully utilized, each program manual is an effective tool for the provider. It provides information about the Medicaid Program, covered and non-covered services, billing procedures and detailed instructions for completing claims.

Obtain provider manuals from the [DMS website](#).

101.100 Provider Manual Organization**11-1-26**

The manuals are organized as follows:

- A. Section I – general information
- B. Section II – program policy and program-specific billing information, including special billing
- C. Section III – generic billing information
- D. Section IV – glossary
- E. Section V – forms and contact information
- F. Notices of Rule Making
- G. Official Notices
- H. Remittance Advice (RA) messages

Sections I, III, IV and V are the same in each manual; only Section II is program- and provider-specific. Separate hyperlinks to other policy-related notifications (items F, G and H above) address either specific providers/programs or all providers. Providers should review both.

The manuals are divided into numbered sections with a heading and a revision date, such as "101.000 Provider Manuals 1-1-20". Text that appears underlined and blue indicates a hyperlink to the information being referenced, and it may be viewed or printed. The paper version contains the same underlined text, though not in blue, so paper users must locate the "linked" information.

101.200 Updates**11-1-26**

Provider manuals are amended ("updated") in accordance with new, repealed or revised federal and state legislative and legal clarifications. Changes and clarifications in DMS medical policy, new administrative or billing procedures and numerous other requirements are issued and implemented when warranted. These changes and clarifications are released to the provider in the form of a manual update, a notice of rule making, an official notice or a remittance advice (RA) message.

Provider manuals are updated automatically on the DMS website. Providers are notified via e-mail when an applicable manual update transmittal is issued. Providers must give Provider Enrollment a valid, current e-mail address to receive such e-mail notification, and report changes as needed. Only revised sections are issued in manual updates along with an update transmittal letter to detail changes. All policy changes including manual updates, notices of rule making,

official notices and RA messages are posted weekly on [What's new for Arkansas Medicaid providers](#). Bookmark this page and review often for the latest provider information.

Policy and procedure changes are highlighted in the electronic media to help providers quickly review changes. Provider manual update transmittals are assigned sequential identification numbers, e.g., Update Transmittal MANUAL-1-11. The transmittal letter identifies any new sections being added and the sections being replaced, deleted, or amended. It provides brief explanations of the revisions. Provider manual update transmittal letters are recorded on the update log following each section of the manual.

For persons maintaining a printed provider manual, the updated manual sections should be manually filed in the provider manual, and the outdated sections should be crossed out or removed, as appropriate. The transmittal letter effective date should be entered on the update log opposite the appropriate update transmittal number. Transmittal letters should be filed immediately following the update log in descending numerical order by transmittal number. Immediately following the transmittal letters should be the notices of rule making, then official notices, both of which are numbered sequentially and should be filed with the most recent first. The RA messages will follow the notices of rule making and official notices, with the most recent filed first.

101.300 Obtaining Provider Manuals 11-1-26

All provider manuals, manual updates, notices of rule making, official notices, and RA messages are available to download or print, without charge, from the [DMS website](#). Instructions to maintain a printed provider manual can be found in Section 101.200.

110.400 Rate Review Process 11-1-26

A provider may request reconsideration of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). The request must be received within twenty (20) calendar days following the application of a rate related policy or procedure, or the notice to the provider of its rate. Upon receipt of the request for review, the DMS Director will give the provider the opportunity for a conference to fully explain the factors involved in the program's rate related policy or procedure. Following review of the matter, the DMS Director will notify the provider of the action to be taken by DMS within twenty (20) calendar days of receipt of the request for review or the date of the program or provider conference.

The provider may request review of the matter by a standing rate review panel if the decision of the DMS Director is unsatisfactory to the provider. The rate review panel will be established by the DMS Director and will include one (1) Department of Human Services staff member, one (1) representative of a relevant provider association, and one (1) member of Department of Human Services (DHS) executive leadership staff (other than the DMS Director), who will serve as chairman.

The provider's request for review by a rate review panel must be postmarked within fifteen (15) calendar days following the notification of the initial decision by the DMS Director. The rate review panel will meet to consider the question(s) within fifteen (15) calendar days after receipt of the request for a review. Questions will be heard by the panel and a recommendation will be submitted to the Medicaid Director. The Medicaid Director may adopt, modify, decline, or remand (send back) the recommendation of the Rate Review Panel.

111.000 DMS and Fiscal Agent Office Hours 11-1-26

A Provider Assistance Center is available for provider billing and reimbursement questions 8:00 a.m. until 5:00 p.m., Monday through Friday, with the exception of state and official holidays. [View or print the Provider Assistance Center contact information.](#)

The Division of Medical Services is available to answer provider questions regarding service coverage not directly addressed within this provider manual 8:00 a.m. until 5:00 p.m., Monday

through Friday, with the exception of state and official holidays. [View or print the Division of Medical Services contact information.](#)

170.100 Introduction

11-1-26

Arkansas Medicaid's Primary Care Case Management (PCCM) Program operates statewide under the authority of the Medicaid State Plan.

- A. Most Medicaid beneficiaries and all ARKids First-B participants must enroll with a primary care provider (PCP), also known as a primary care case manager (PCCM). PCPs:
 - 1. provide primary care services and health education;
 - 2. make referrals for medically necessary specialty provider services, hospital care, and other services;
 - 3. assist their enrollees with locating medical services;
 - 4. coordinate and monitor their enrollees' prescribed medical and rehabilitation services.
- B. Medicaid enrollees may only receive services from their PCP unless their PCP refers them to another provider, or unless they access a service that does not require a PCP referral.
- C. If a beneficiary does not have a primary care provider, Arkansas Medicaid will allow up to four (4) visits per state fiscal year without a Primary Care Provider (PCP) referral to a hospital affiliated Walk-in Clinic or Emergent Clinic.
- D. These visits apply to all related benefit limits.

171.000 Primary Care Provider Participation

171.100 PCP-Qualified Physicians, Advanced Practice Nurse Practitioners, Physician Assistants, and Certified Nurse Specialists

11-1-26

- A. Primary Care Provider (PCP)-qualified physicians are those whose sole or primary specialty is:
 - 1. Family practice;
 - 2. General practice;
 - 3. Internal medicine;
 - 4. Pediatrics and adolescent medicine; or
 - 5. Obstetrics and gynecology.
- B. Obstetricians and gynecologists may choose to enroll as PCPs.
- C. Providers with multiple specialties may choose to enroll as PCPs, if a secondary or tertiary specialty in their Medicaid provider file is listed in part A above.
- D. All other PCP-qualified physicians must enroll as PCPs.
- E. Advanced practice registered nurses (APRN) licensed by the Arkansas State Board of Nursing may choose to enroll as PCPs.
- F. Clinical Nurse Specialists may choose to enroll as PCPs.
- G. Certified Nurse-Midwives may choose to enroll as PCPs.

- H. Physician Assistants authorized by a supervising physician may choose to enroll as PCPs. When initially enrolling with Medicaid to be recognized as a PCP, a physician assistant shall provide written authorization that is signed and dated by his or her supervising physician. In addition, the supervising physician must be actively enrolled in Arkansas Medicaid.

171.110 Exclusions**11-1-26**

- A. Providers whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.
- B. Physician group practices may not be PCPs.

171.120 Hospital Admitting Privileges Requirement**11-1-26**

- A. Only providers with hospital admitting privileges may be PCPs.
- B. The state may waive this requirement to help ensure adequate access to services when:
 - 1. A provider names another provider with hospital admitting privileges and with whom he or she has an agreement to handle hospital admissions on the primary care case manager (PCCM) contract.
 - 2. A copy of the providers' agreement must be submitted with the PCCM contract.

171.130 EPSDT Agreement Requirement**11-1-26**

- A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) program.
- B. Internists, obstetricians, gynecologists, and providers who customarily carry a caseload of patients who are twenty-one (21) years of age or older are not required to furnish EPSDT screens. However, should these providers opt to participate in the EPSDT program, they must sign the EPSDT agreements.

171.160 PCP In State and Trade-Area Restriction**11-1-26**

PCPs must practice in Arkansas except when the following conditions apply:

- A. PCP-qualified providers in the trade-area cities (Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee, and Texarkana, Texas), may be PCPs.
- B. The state may waive the trade-area city rule for border-state providers who are not in trade-area cities to ensure adequate access to services.

171.200 PCCM Enrollee and Caseload Management**171.210 ConnectCare Caseload Maximum and PCP Caseload Limits****11-1-26**

- A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 2500:
 - 1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.

2. The state may permit higher maximum caseloads for PCPs who state in writing that the default maximum will create hardship for them, their patients, or the community they serve.
- B. The state will not require a PCP to accept a caseload greater than the PCP's requested caseload maximum.
- C. A PCP may increase or decrease his or her maximum desired caseload by any amount, up to the default maximum by completing and submitting an electronic [DMS-2608, PCP Agreement](#) form. The completed form should be uploaded to the [Health Care Provider Portal](#) (for help, see the job aid [How to Upload Documents](#)).
- D. To request an increase in a PCP caseload above the default maximum, the PCP must submit to the Provider Enrollment Unit an electronic [DMS-2608, PCP Agreement](#) form along with a signed letter explaining the necessity by uploading to the [Health Care Provider Portal](#). (See the job aid [How to Upload Documents](#) if needed.) The State must approve requests that exceed the maximum caseload.
- E. PCPs are encouraged to review their caseload for inactive patients to determine if those patients should be removed from their caseload prior to making a request for an increase of their caseload. To do so, PCPs may use their DMS caseload report in MMIS. If it is determined that the inactive patients should be removed from his or her caseload, the PCP must:
 1. Contact the patient in writing at least thirty (30) days in advance of the effective date of the termination to give the patient the option to remain an active patient by making a visit to the PCP. If the patient does not choose to make a visit to the PCP, the termination can be effective at the end of thirty (30) calendar days.
 2. With approval from his or her Provider Relations Representative, the PCP may add and see new patients during the thirty (30) calendar day process of inactive patients.
 3. The notice must state the inactive enrollee has thirty (30) calendar days in which to enroll with a different PCP.
 4. The PCP must forward a copy of the notice to the inactive enrollee, and their Provider Relations Representative and ConnectCare.

171.220 Illegal Discrimination**11-1-26**

- A. A PCP may not reject a potential enrollee on the basis that they are a Medicaid beneficiary if the PCP has openings on his or her caseload and may not discriminate against a beneficiary because of the individual's age, sex, race, national origin, or type of illness or condition.
- B. Rejecting a potential enrollee based on the individual's age or sex does not constitute unlawful discrimination if the provider customarily sees only patients of one sex, a particular age range, or both. For instance:
 1. An obstetrician/gynecologist doesn't treat males, so he or she is not expected to enroll males.
 2. A pediatrician specializing in adolescent medicine may only see patients in a particular age range, such as twelve (12) through eighteen (18) years old.
- C. PCPs may specify the minimum and maximum ages of Medicaid and ARKids First-B enrollees they will accept.

171.230 Primary Care Case Management Fee**11-1-26**

- A. In addition to reimbursing PCPs on a fee for service basis for provider services, Arkansas Medicaid pays them a monthly case management fee for each enrollee on their caseloads.

- B. The amount due for each month is determined by multiplying the established case management fee by the number of enrollees on the PCP's caseload.
 - 1. Medicaid pays case management fees quarterly.
 - 2. The accompanying Medicaid Remittance and Status Report (RA) itemizes the payments, lists the number of enrollees, and identifies each enrollee's enrollment months.
 - 3. Enrollees are listed alphabetically by name, with their Medicaid identification numbers and addresses displayed.
- C. PCP case management fees are paid according to the PCP's direction. The PCP may choose to have the case management fee paid to his or her individual provider ID number or to the group provider ID number with whom the PCP is affiliated.
- D. If the PCP's case management fees are paid to a group and the PCP changes his or her affiliation, the PCP must submit a new PCP Agreement Form to Provider Enrollment within thirty (30) calendar days of changing affiliation. The PCP must notify the beneficiaries on his or her caseload of the change.
- E. If the PCP fails to submit a new PCP Agreement Form, the case management fees will pay to the provider of record until a new PCP Agreement Form is received by Provider Enrollment.
- F. If a Group Affiliation Form is received by Provider Enrollment to disassociate a PCP from a group but the PCP Agreement Form is not received, the case management fees will be paid to the individual PCP's provider ID number.
- G. If the PCP's case management fees were paid to a group in which the PCP is no longer affiliated, it is the responsibility of that group to reimburse Medicaid the fees they were not entitled to receive.
- H. **No case management fees will be back paid to a PCP who has failed to follow the process described in Paragraph D of this Section.**
- I. Case management fees will be reconciled at least quarterly and may be reconciled at any time determined necessary to resolve immediate issues.

171.400 PCP Referrals**11-1-26**

- A. Referrals may be only for medically necessary services, supplies or equipment.
- B. The PCP must give enrollees free choice by naming two or more providers of the same type or specialty when making referrals.
- C. PCPs are not required to make retroactive referrals.
- D. Because PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.
- E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)
- F. The number of times a referral may be renewed is not limited, but renewals must be medically necessary and at least every six (6) months (with exceptions as noted in part E, above).

- G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.
- H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in Section 172.100.
- I. Some services such as personal care require an Independent Assessment. Please refer to the Independent Assessment Guide for related information and referral processes.

171.410 PCCM Referrals and Documentation**11-1-26**

- A. Medicaid provides an optional referral form, DMS-2610, to facilitate referrals. [View or print form DMS-2610.](#)
 - 1. Additionally, PCP referrals may be oral, by note, or by letter but must contain all components of the DMS-2610 form.
 - 2. Referrals may be faxed.
- B. Regardless of how the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.
 - 1. Medicaid also requires documentation of the referral in the patient's chart by the provider to whom the referral is made.
 - 2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

171.500 Primary Care Case Management Activities and Services**11-1-26**

A ConnectCare PCP is also known as a primary care case manager (PCCM). He or she provides primary care provider services as well as these additional services:

- A. Health education;
- B. Assessing each enrollee's medical condition, initiating and recommending treatment or therapy when needed;
- C. Initiating referrals to specialty physicians and for hospital care and other medically necessary services;
- D. Assisting with locating medical services needed;
- E. Coordinating, prescribed medical and rehabilitation services with other professionals;
- F. Monitoring enrollees prescribed medical and rehabilitation services.

171.510 Access Requirements for PCPs**11-1-26**

- A. A PCP must have hours of operation that are reasonable and adequate to serve his or her patients.
 - 1. The PCP's office must be open to Medicaid enrollees during the same hours and for the same number of hours as it is for self-pay and insured patients.
 - 2. ConnectCare enrollees must have the same access to emergency and non-emergency medical services as private pay and insured people have .
- B. A PCP must make available twenty-four (24) hours, seven (7) days per week telephone access to a live voice (an employee of the primary care provider or an answering service)

or to an answering machine that will immediately page an on-call medical professional. The on-call professional will:

1. Provide information and instructions for treating emergency and non-emergency conditions,
 2. Make appropriate referrals for non-emergency services, and
 3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.
- C. A PCP must respond to after-hours calls regarding non-emergencies within thirty (30) minutes.
1. PCPs must make the after-hours telephone number as widely available as possible to their patients.
 2. When using an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and the instructions are up to date.
- D. PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.
- E. Regarding access to services, PCPs are required to provide the same level of service for their ConnectCare enrollees as they provide for their insured and privately-paid patients.
- F. Providers and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations, and any other pertinent information to the PCP to include in the patient's medical record.
- G. A PCP may not refer ConnectCare enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

171.601 PCP Substitutes; General Requirements

11-1-26

- A. Provider substituting for PCPs are not required to be PCPs themselves.
- B. In addition to the rules that apply to physician substitutes (found in the Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual), providers substituting for PCPs are subject to the following regulations:
1. The PCP and the substitute must document the substitution in each enrollee's record(s) as a referral and include the reason for the substitution.
 2. The substitute provider must furnish the PCP's name and provider identification number to any other provider to whom he or she refers the patient.

171.610 PCP Substitutes - Rural Health Clinics and Physician Group Practices

11-1-26

When a PCP is affiliated with a rural health clinic (RHC) or is a member of a provider group, other providers affiliated with the RHC or other members of the provider group may substitute for the PCP when he or she is unavailable.

- A. Acceptable reasons for a PCP to be unavailable include (but are not limited to):
1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
 2. The PCP is in surgery or attending a delivery.

3. An unusual number of patients need services outside the PCP's normal working hours.
 4. The PCP is ill, on vacation, or other leave of absence.
- B. Habitual over-scheduling of patients or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

171.620 PCP Substitutes - Individual Practitioners

11-1-26

A PCP that is an individual practitioner must designate a substitute provider to take calls, see patients, and make appropriate referrals when the PCP is unavailable.

- A. Acceptable reasons for a PCP to be unavailable include (but are not limited to):
1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
 2. The PCP is in surgery or attending a delivery.
 3. An unusual number of patients need services outside the PCP's normal working hours.
 4. The PCP is ill, on vacation, or other leave of absence.
- B. Habitual over-scheduling or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

172.300 Automated PCP Enrollment Verification

11-1-26

- A. An electronic Medicaid eligibility verification response includes PCP name and telephone number, and the beginning date of the current enrollment period.
1. If no current PCP is displayed on the eligibility response, the individual is not enrolled with a PCP.
 2. Beneficiaries with no PCP should be referred to the ConnectCare Helpline for information and assistance. [View or print the ConnectCare Helpline contact information.](#)
- B. Medicaid beneficiaries and ARKids First-B participants—regardless of whether they are enrolled with a PCP—are responsible for all charges for services they receive without obtaining required referrals.

173.000 PCCM Selection, Enrollment and Transfer

11-1-26

- A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP to obtain a PCP referral for medical services.
1. Newly eligible individuals are given opportunities to enroll.
 2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders of the advantages of PCP enrollment from ConnectCare.
- B. An individual must select a PCP that is located near his or her residence.
1. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence, or a county that adjoins a county adjacent to the county of residence.
 2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection and Enrollment at Local County DHS Offices**11-1-26**

- A. Medicaid applicants receive a description and explanation of ConnectCare from DHS county office staff.
 - 1. By means of a Primary Care Provider Selection and Change form (DMS-2609 or DCO-2609,) an applicant indicates the first, second, and third choice for PCPs of each family member included in the Medicaid case.
 - 2. Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.

173.200 PCP Selection and Enrollment at PCP Offices and Clinics**11-1-26**

PCP Providers may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS.)

- A. Enrollees must document their PCP choice on a Primary Care Provider Selection and Change form (DMS-2609 or DCO-2609.)
 - 1. The form must be completed, dated, and signed by the enrollee.
 - 2. The enrollee may request and receive a copy of the form.
 - 3. The PCP office must retain a copy of the form in the enrollee's file.
- B. Enrolling the beneficiary is performed by accessing the VRS and following the instructions. [View or print Voice Response System \(VRS\) contact information.](#)
- C. When a PCP wants to add a new enrollee, but the PCP's Medicaid caseload is full or when a PCP wants to increase or decrease his or her caseload limit:
 - 1. The PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, up to the default maximum by submitting a signed request to their Medicaid Managed Care Services (MMCS) Provider Relations Representative or, on-line through the [Provider Information Portal](#).
 - 2. An increase in PCP caseload above the default maximum requires a written request to the Provider Relations Representative. [View or print Provider Relations Representative contact information.](#) Prior to making the request for the increase of a caseload that is already at maximum, the PCP is encouraged to review his or her caseload using the DMS caseload report for inactive patients in MMIS to determine whether those patients should be removed. PCPs must follow the guidelines within Section 171.210 to notify patients regarding their removal from the PCP's caseload.

173.300 PCP Selection and Enrollment Through the ConnectCare HelpLine**11-1-26**

- A. PCP enrollment through the ConnectCare HelpLine is recommended.
- B. ConnectCare HelpLine is operated by Medicaid Outreach and Education for ConnectCare.
 - 1. ConnectCare HelpLine staff are available for PCP enrollments and transfers 8:00 a.m. – 5:00 p.m. Monday through Friday.
 - 2. The HelpLine number (1-800-275-1131) is prominently displayed in ConnectCare publications, frequently in more than one place. [View or print ConnectCare contact information.](#)
 - 3. HelpLine staff members help Medicaid beneficiaries and ARKids First-B participants locate PCPs in their area.

4. HelpLine staff can help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400 PCP Selection and Enrollment at Participating Hospitals**11-1-26**

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

- A. Enrollment is by means of a Primary Care Provider Selection and Change form (DMS-2609 or DCO-2609) and the voice response system (VRS).
 1. Hospital personnel enter the PCP selection via the VRS.
 2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
 3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within twenty-four (24) hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.
- B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.
- C. The enrollee may request and receive a copy of the completed selection form.
- D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.500 PCP Selection for Supplemental Security Income (SSI) Beneficiaries**11-1-26**

Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

- A. When an SSI beneficiary's Medicaid eligibility determination is made, the Arkansas Medicaid fiscal agent generates a letter describing ConnectCare.
 1. It includes instructions for selecting and enrolling with a PCP.
 2. A Primary Care Provider Selection and Change form (DCO-2609) is enclosed in the mailing.
- B. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid beneficiaries.

173.600 Transferring PCP Enrollment**173.610 PCP Transfers by Enrollee Request****11-1-26**

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

- A. Enrollees are encouraged to use the ConnectCare HelpLine when transferring their enrollment from one PCP to another. Enrollees may change their PCP by calling ConnectCare at 1-800-275-1311 or by completing the PCP Change Request form online at www.seeyourdoc.org.
- B. Enrollees may also change their PCP at the local DHS county office in the enrollee's county of residence, but the enrollee or the enrollee's parent or guardian must request the transfer in writing by means of an Arkansas Medicaid Primary Care Provider Selection and Change form (DMS-2609 or DCO-2609).

173.620 PCP Transfers by PCP Request**11-1-26**

A PCP may request 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 two (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. The PCP must give the enrollee written notice to transfer his or her enrollment to another PCP at least thirty (30) days in advance of the effective date of the termination.
 - 1. The notice must state that the enrollee has thirty (30) days to enroll with a different PCP.
 - 2. The PCP must forward a copy of the notice to the enrollee and the local DHS office in the enrollee's county of residence, and to their Provider Relations Representative, and ConnectCare.
- C. The PCP continues as the enrollee's primary care provider during the thirty (30) days or until the individual transfers to another PCP, whichever comes first.

173.630 PCP Enrollment Transfers Initiated by the State**11-1-26**

The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers happen because DMS, in exercising its regulatory function, must sometimes sanction, suspend, or terminate a provider.

- A. For instance, a provider may lose his or her PCP or Medicaid contract for:
 - 1. Failure to meet PCP or Medicaid contractual obligations;
 - 2. Proven and consistent excessive utilization;
 - 3. Unnecessarily limited utilization of medically necessary services.
- B. When the State terminates a PCP's contract, DHS Division of Medical Services (DMS) contacts the PCP's enrollees with instructions for transferring their PCP enrollment.

Instructions must include beneficiary access to a listing of all PCPs who have an open panel and are accepting Medicaid patients within the enrollee's geographical area.

TOC not required

221.100 ARKids First-B Medical Care Benefits

2-1-2211-1-
26

Listed below are the covered services for the ARKids First-B program are listed in the chart below. This chart also includes benefits, whether Prior Authorization or a Primary Care Physician/provider (PCP) referral is required, and requirements, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	\$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	\$10 per visit
Audiological Services (only Tympanometry, CPT procedure code****, when the diagnosis is within the ICD range (View ICD codes ..))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	\$10 per visit
Chiropractor	Medical Necessity	PCP Referral	\$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	\$10 per visit
Durable Medical Equipment	Medical Necessity \$500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	\$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	\$10 per visit
Assessment	Medical Necessity	None	\$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	\$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30))	PCP Referral	\$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over <u>47</u> days if age 1 or over	10% of first inpatient day
<u>Hospital, Critical Access</u>	<u>Medical Necessity</u>	<u>PA on stays over 4 days if age 1 or over</u>	<u>10% of first inpatient day</u>
Hospital, Outpatient	Medical Necessity	PCP referral	\$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	\$10 per visit
Medical Supplies	Medical Necessity Benefit of \$125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding \$125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	~~PCP Referral~~ PA on treatment services	\$10 per visit
School-Based Mental Health	Medical Necessity	PA Required ~~(See Section 250.000 of the School-Based Mental Health provider manual.)~~	\$10 per visit
Nurse Practitioner <u>Physician Assistant,</u> <u>Clinical Nurse Specialist</u>	Medical Necessity	PCP Referral	\$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	\$10 per visit
Podiatry	Medical Necessity	PCP Referral	\$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to \$5 per prescription (Must use generic, if available)***

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None
Rural Health Clinic	Medical Necessity	PCP Referral	\$10 per visit
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	\$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of \$5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to \$5.00 per prescription.

[****View or print the procedure codes for ARKids First-B procedures and services.](#)

The ARKids First-B Program supports preventive medicine for beneficiaries by reimbursing primary care ~~physicians~~providers (PCPs) who provide medical preventive health screens and qualified screening providers to whom PCPs refer beneficiaries. ARKids First-B outreach efforts ~~vigorously~~ promote the program's emphasis on preventive medical health care. Beneficiary cost sharing does not apply to covered preventive medical health screens, including those for newborns.

The supplemental eligibility response request to an ARKids First-B beneficiary's identification card will indicate to the provider the date of the beneficiary's last preventive health screen.

[View or print the procedure codes for ARKids First-B procedures and services.](#)

This information should be reviewed and verified, along with the beneficiary's eligibility, prior to performing a service. This information will assist the ~~beneficiary's PCP or preventive health screen~~ provider in determining the beneficiary's eligibility for the service and ensuring that preventive health screens are performed in a timely manner ~~in compliance~~that complies with the periodicity chart ~~for ARKids First-B beneficiaries.~~

Newborn screens do not require a PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

Nurse practitioners, physician assistants, and clinical nurse specialists ~~in addition to newborn preventive health screens~~, are authorized to provide other newborn preventive health screens and other preventive health screens.

When a nurse practitioner, physician assistant, or clinical nurse specialist who is not the beneficiary's ~~with a PCP~~ performs preventive health screens other than the newborn screen, a PCP referral is required. [Refer to Section 262.130](#) for preventive health screens procedure codes.

TOC not required

221.100 ARKids First-B Medical Care Benefits

11-1-26

Covered services for the ARKids First-B program are listed in the chart below. The chart includes benefits, prior authorization or Primary Care Provider (PCP) referral requirements, and specifies the cost-sharing requirements.

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Ambulance (Emergency Only)	Medical Necessity	None	\$10 per trip
Ambulatory Surgical Center	Medical Necessity	PCP Referral	\$10 per visit
Audiological Services (<u>only</u> Tympanometry, CPT procedure code****, when the diagnosis is within the ICD range (View ICD codes ..))	Medical Necessity	None	None
Certified Nurse-Midwife	Medical Necessity	PCP Referral	\$10 per visit
Chiropractor	Medical Necessity	PCP Referral	\$10 per visit
Dental Care	Routine dental care and orthodontia services	None – PA for inter-periodic screens and orthodontia services	\$10 per visit
Durable Medical Equipment	Medical Necessity \$500 per state fiscal year (July 1 through June 30) minus the coinsurance/cost-share. Covered items are listed in Section 262.120	PCP Referral and Prescription	10% of Medicaid allowed amount per DME item cost-share
Emergency Dept. Services			
Emergency	Medical Necessity	None	\$10 per visit
Non-Emergency	Medical Necessity	PCP Referral	\$10 per visit
Assessment	Medical Necessity	None	\$10 per visit
Family Planning	Medical Necessity	None	None
Federally Qualified Health Center (FQHC)	Medical Necessity	PCP Referral	\$10 per visit

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Home Health	Medical Necessity (10 visits per state fiscal year (July 1 through June 30))	PCP Referral	\$10 per visit
Hospital, Inpatient	Medical Necessity	PA on stays over 7 days if age 1 or over	10% of first inpatient day
Hospital, Critical Access	Medical Necessity	PA on stays over 4 days if age 1 or over	10% of first inpatient day
Hospital, Outpatient	Medical Necessity	PCP referral	\$10 per visit
Inpatient Psychiatric Hospital and Psychiatric Residential Treatment Facility	Medical Necessity	PA & Certification of Need is required prior to admittance	10% of first inpatient day
Immunizations	All per protocol	None	None
Laboratory & X-Ray	Medical Necessity	PCP Referral	\$10 per visit
Medical Supplies	Medical Necessity Benefit of \$125/mo. Covered supplies listed in Section 262.110	PCP Prescriptions PA required on supply amounts exceeding \$125/mo	None
Mental and Behavioral Health, Outpatient	Medical Necessity	PA on treatment services	\$10 per visit
School-Based Mental Health	Medical Necessity	PA Required	\$10 per visit
Nurse Practitioner Physician Assistant, Clinical Nurse Specialist	Medical Necessity	PCP Referral	\$10 per visit
Physician	Medical Necessity	PCP referral to specialist and inpatient professional services	\$10 per visit
Podiatry	Medical Necessity	PCP Referral	\$10 per visit
Prenatal Care	Medical Necessity	None	None
Prescription Drugs	Medical Necessity	Prescription	Up to \$5 per prescription (Must use generic, if available)***
Preventive Health Screenings	All per protocol	PCP Administration or PCP Referral	None

Program Services	Benefit Coverage and Restrictions	Prior Authorization/ PCP Referral*	Co-payment/ Coinsurance/ Cost Sharing Requirement**
Rural Health Clinic	Medical Necessity	PCP Referral	\$10 per visit
Speech-Language Therapy	Medical Necessity 4 evaluation units (1 unit =30 min) per state fiscal year 4 therapy units (1 unit=15 min) daily	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Occupational Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Physical Therapy	Medical Necessity 2 evaluation units per state fiscal year	PCP Referral Authorization required on extended benefit of services	\$10 per visit
Vision Care			
Eye Exam	One (1) routine eye exam (refraction) every 12 months	None	\$10 per visit
Eyeglasses	One (1) pair every 12 months	None	None

*Refer to your Arkansas Medicaid specialty provider manual for prior authorization and PCP referral procedures.

**ARKids First-B beneficiary cost-sharing is capped at 5% of the family's gross annual income.

***ARKids First-B beneficiaries will pay a maximum of \$5.00 per prescription. The beneficiary will pay the provider the amount of co-payment that the provider charges non-Medicaid purchasers up to \$5.00 per prescription.

[**View or print the procedure codes for ARKids First-B procedures and services.](#)**

222.710 Introduction

11-1-26

The ARKids First-B Program supports preventive medicine for beneficiaries by reimbursing primary care providers (PCPs) who provide medical preventive health screens and qualified screening providers to whom PCPs refer beneficiaries. ARKids First-B outreach efforts promote the program's emphasis on preventive medical health care. Beneficiary cost sharing does not apply to covered preventive medical health screens, including those for newborns.

The supplemental eligibility response request to an ARKids First-B beneficiary's identification card will indicate to the provider the date of the beneficiary's last preventive health screen.

[View or print the procedure codes for ARKids First-B procedures and services.](#)

This information should be reviewed and verified, along with the beneficiary's eligibility, prior to performing a service. This information will assist the provider in determining the beneficiary's eligibility for the service and ensure that preventive health screens are performed in a timely manner that complies with the periodicity chart.

Newborn screens do not require a PCP referral.

Certified nurse-midwives may provide newborn screens ONLY.

Nurse practitioners, physician assistants, and clinical nurse specialists are authorized to provide newborn preventive health screens and other preventive health screens.

When a nurse practitioner, physician assistant, or clinical nurse specialist who is not the beneficiary's PCP performs preventive health screens other than the newborn screen, a PCP referral is required. [Refer to Section 262.130](#) for preventive health screens procedure codes.

TOC required

204.101 Documentation of Services

711-1-2617

Home Health Providers must maintain the following records for patients of all ages.

- A. Patient assessments.
- B. Plans of care.
- C. Physical therapy evaluations.
- D. Treatment plans when applicable.
- E. Case notes.
- F. Progress notes from each visit by nurses, aides, physical therapy assistants and physical therapists.
- G. *Pro re nata* (PRN) visits and the medical justification for each such unscheduled visit.
- H. A face to face encounter with the beneficiary must meet the following requirements:
 - 1. Regarding initiation of Home Health services, the face to face encounter must be related to the primary reason the beneficiary requires Home Health services and must occur within the ninety (90) days before or the thirty (30) days after the start of services.
 - 2. Regarding initiation of medical equipment, the face to face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
 - 3. Conducted by one of the following practitioners:
 - a. The primary care physician.
 - b. A nurse practitioner working in collaboration with the primary care physician.
 - c. A certified nurse midwife by the scope of practice.
 - d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to A.C.A. § 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.
 - e. The attending acute or post-acute physician.
 - 4. The non-physician must communicate the clinical findings of that face to face to the ordering physician. Those clinical findings must be incorporated into a document included in the beneficiary's medical record.
 - 5. The physician ordering the services must assure clinical correlation between the face to face encounter and the associated Home Health document:
 - a. The primary reason the patient requires Home Health services.
 - b. The start of Home Health services.
 - c. The practitioner who conducted the encounter and the date of the encounter.
 - d. The face-to-face encounter may occur through telemedicine, when applicable to the program manual of the performing provider of the encounter.

~~E. No payment may be made for medical equipment, supplies or appliances unless the primary care physician or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements as listed in D.3. The certified Nurse Midwife must meet the home health documentation requirements found in Section 206.000 of the Home Health Provider Manual.~~

213.600 Certified Nurse-Midwife Services Benefit Limit

~~711-1-265~~

Beneficiaries age twenty-one (21) and older are limited to sixteen (16) visits per state fiscal year (July 1 through June 30) for services provided by a certified nurse-midwife, in combination with services provided by the following: physician's services, physician assistants, clinical nurse specialists, advanced nurse practitioners, rural health clinic services, federally qualified health centers, medical services furnished by a dentist, ~~office~~-medical services furnished by an optometrist, ~~services provided by an advanced nurse practitioner,~~ or any combination thereof ~~the~~ six.

For example: A beneficiary who has had two office medical visits to the dentist, one office medical visit to an optometrist and two visits to a physician has used five of the limited sixteen (16) visits per state fiscal year.

~~The following services are counted toward the sixteen (16) visits per state fiscal year limit established for the Certified Nurse-Midwife Program:~~

- ~~A. Certified nurse-midwife services~~
- ~~B. Physician services in the office, patient's home, or nursing facility~~
- ~~C. Rural health clinic (RHC) core services~~
- ~~D. Medical services provided by a dentist~~
- ~~E. Medical services furnished by an optometrist~~
- ~~F. Advanced nurse practitioner services~~

Office visits ~~coded with obstetrical visit procedure codes~~ are not counted toward the visit limit when the following are the primary diagnosis being treated: malignant Neoplasm, renal failure, HIV/AIDS, opioid use disorder when visits are part of a Medication Assisted Treatment (MAT) plan, and pregnancy. All other office visits count toward the established sixteen (16) visit limit. Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.000 of this manual for procedures for obtaining extension of benefits.

Beneficiaries under age twenty-one (21) years of age in the Early and Periodic Screening, Diagnostic, and Treatment in the Child Health Services (EPSDT) Program are not benefit limited.

215.200 Family Planning Coverage Information

~~4-1-2411-1-26~~

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.
 - 1. Family planning services do not require a PCP referral.
 - 2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.

3. Family Planning prescriptions are unlimited and do not count toward the prescription benefit limit.
 4. Extension of benefits is not available for family planning services.
 5. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per client/beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this provider manual for service descriptions and coverage information.
- C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.
- D. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local, and area providers who are qualified to provide family planning services. Listed providers include:
1. Local units of the Arkansas Department of Health ~~local health units~~
 2. Obstetricians and gynecologists
 3. Nurse practitioners
 4. Rural Health Clinics
 5. Federally Qualified Health Centers
 6. Family planning clinics
 7. Physicians
 8. Physician Assistants
 9. Clinical Nurse Specialists
- E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
 2. 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 an inpatient stay. On the outpatient claim, see LARC billing combinations for billing codes. Ensure the applicable NDC code is submitted on the claim.
 3. Physician charges can be billed for insertion and 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. See LARC billing combinations for billing codes.
 4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.
- F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

215.250 Contraception

**12-1-2111-
1-26**

- A. Prescription and Non-Prescription Contraceptives

1. Medicaid pays for birth control pills and other prescription contraceptives as a family planning prescription benefit.
 2. Medicaid pays for non-prescription contraceptives as a family planning benefit, when a certified nurse-midwife writes a prescription for them.
- B. Contraceptive Implant Systems
1. Medicaid covers the contraceptive implant systems, including implants and supplies.
 2. Medicaid covers insertion, removal, and removal with reinsertion.
- C. Intrauterine Devices (IUDs)
1. Medicaid pays for IUDs as a family planning benefit.
 2. Alternatively, Medicaid reimburses physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and clinics who supply the IUD at the time of insertion.
 3. Medicaid pays physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and clinics for IUD insertion and removal.
- D. Medroxyprogesterone Acetate
4. Medicaid covers medroxyprogesterone acetate injections for birth control.

252.000

Rate Appeal Review Process

711-1-206

~~A provider may request reconsideration of a Medicaid Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of a procedure rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.~~

~~If the decision of the Assistant Director of the Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel, established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairman.~~

~~The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

A provider may request review of a Medicaid program rate policy or procedure by writing to the Assistant Director, Division of Medical Services. Refer to **Section I, 110.400** to get instructions for how to request a rate review.

TOC required**204.101 Documentation of Services****11-1-26**

The certified Nurse Midwife must meet the home health documentation requirements found in Section 206.000 of the [Home Health Provider Manual](#).

213.600 Certified Nurse-Midwife Services Benefit Limit**11-1-26**

Beneficiaries age twenty-one (21) and older are limited to sixteen (16) visits per state fiscal year (July 1 through June 30) for services provided by a certified nurse-midwife, in combination with services provided by the following: physicians, physician assistants, clinical nurse specialists, advanced nurse practitioners, rural health clinics, federally qualified health centers, medical services furnished by a dentist, medical services furnished by an optometrist, or any combination thereof.

For example: A beneficiary who has had two office medical visits to the dentist, one office medical visit to an optometrist and two visits to a physician has used five of the limited sixteen (16) visits per state fiscal year.

Office visits are not counted toward the visit limit when the following are the primary diagnosis being treated: malignant Neoplasm, renal failure, HIV/AIDS, opioid use disorder when visits are part of a Medication Assisted Treatment (MAT) plan, and pregnancy. All other office visits count toward the established sixteen (16) visit limit. Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.000 of this manual for procedures for obtaining extension of benefits.

Beneficiaries under twenty-one (21) years of age in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program are not benefit limited.

215.200 Family Planning Coverage Information**11-1-26**

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, nurse practitioners, certified nurse-midwives, clinics, and hospitals for a comprehensive range of family planning services.
 - 1. Family planning services do not require a PCP referral.
 - 2. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
 - 3. Family Planning prescriptions are unlimited and do not count toward the prescription benefit limit.
 - 4. Extension of benefits is not available for family planning services.
 - 5. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Other than full coverage aid categories, Arkansas Medicaid covers one basic family planning examination and three periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 215.200 through 215.260 of this provider manual for service descriptions and coverage information.
- C. Certified nurse-midwives desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 215.210 through 215.260, to Medicaid beneficiaries of childbearing age.

- D. Certified nurse-midwives preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local, and area providers who are qualified to provide family planning services. Listed providers include:
1. Local units of the Arkansas Department of Health
 2. Obstetricians and gynecologists
 3. Nurse practitioners
 4. Rural Health Clinics
 5. Federally Qualified Health Centers
 6. Family planning clinics
 7. Physicians
 8. Physician Assistants
 9. Clinical Nurse Specialists
- E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during postpartum, while the beneficiary remains in an inpatient setting.

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04).
 2. 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 an inpatient stay. On the outpatient claim, [see LARC billing combinations for billing codes](#). Ensure the applicable NDC code is submitted on the claim.
 3. Physician charges can be billed for insertion and 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. [See LARC billing combinations for billing codes](#).
 4. The 340-B rules and modifiers to the LARC code combinations apply, when applicable.
- F. Complete billing instructions for family planning services are in Sections 215.200-215.260.

215.250 Contraception

11-1-26

- A. Prescription and Non-Prescription Contraceptives
1. Medicaid pays for birth control pills and other prescription contraceptives as a family planning prescription benefit.
 2. Medicaid pays for non-prescription contraceptives as a family planning benefit, when a certified nurse-midwife writes a prescription for them.
- B. Contraceptive Implant Systems
1. Medicaid covers the contraceptive implant systems, including implants and supplies.
 2. Medicaid covers insertion, removal, and removal with reinsertion.
- C. Intrauterine Devices (IUDs)
1. Medicaid pays for IUDs as a family planning benefit.

2. Alternatively, Medicaid reimburses physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and clinics who supply the IUD at the time of insertion.
3. Medicaid pays physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified nurse-midwives, and clinics for IUD insertion and removal.

D. Medroxyprogesterone Acetate

Medicaid covers medroxyprogesterone acetate injections for birth control.

252.000 Rate Review Process

11-1-26

A provider may request review of a Medicaid program rate policy or procedure by writing to the Assistant Director, Division of Medical Services. Refer to [Section I](#), 110.400 to get instructions for how to request a rate review.

TOC required**214.000 PCP Referral Requirements****4-1-0911-1-
26**

The primary care ~~physician-provider~~ (PCP), the PCP entity (e.g., FQHC), or a medically qualified member of the PCP's staff must administer the periodic complete medical screen, or the PCP may make a referral to another qualified Medicaid provider to administer the screen. Qualified Medicaid providers to whom referrals may be made include Medicaid-enrolled nurse practitioners, clinical nurse specialists, physician assistants, and school based providers certified as comprehensive screening providers. Routine newborn care, dental screens, visual screens, hearing screens, and immunizations for childhood diseases are exempt from this referral requirement.

232.000 Rate Appeal Review Process**10-13-0311-
1-26**

A provider may request reconsideration review of a Medicaid program decision-rate policy or procedure by writing to the Assistant Director, Division of Medical Services. Refer to Section I, 110.400 to get instructions for how to request a rate review. ~~This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program and/or provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the program and/or provider conference.~~

~~If the provider disagrees with the decision of the Assistant Director of the Division of Medical Services, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.~~

~~The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director of the Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for the appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

242.100 Procedure Codes**2-4-
2211-1-
26**

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

✱(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

¹ Exempt from PCP referral requirements

² Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

NOTES

- A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.
- B. New-born screenings can be performed by a Certified Nurse Midwife, Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner without a PCP referral.
- C. Procedure codes, used in conjunction with the **EP and H9 modifiers**, are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)
- D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. **May be billed on the CMS-1500 claim form, by paper or electronically.** ([View or print a CMS-1500 sample form.](#)) **May also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**
- E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.
- F. Immunizations and laboratory tests may be billed separately from comprehensive screens.
- G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.
- H. May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections ONLY when the provider administers, but does not supply the drug.
 - 1. Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
 - 2. Cannot be billed to administer any medication given for family planning purposes.
 - 3. Cannot be billed when the drug administered is not FDA approved.
- I. Procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. **The P**procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Claims require National Place of Service code "11". **The P**procedure code is limited to beneficiaries under age twenty-one (21).

TOC required**214.000 PCP Referral Requirements****11-1-26**

The primary care provider (PCP), the PCP entity (e.g., FQHC), or a medically qualified member of the PCP's staff must administer the periodic complete medical screen, or the PCP may make a referral to another qualified Medicaid provider to administer the screen. Qualified Medicaid providers to whom referrals may be made include Medicaid-enrolled nurse practitioners, clinical nurse specialists, physician assistants, and school based providers certified as comprehensive screening providers. Routine newborn care, dental screens, visual screens, hearing screens, and immunizations for childhood diseases are exempt from this referral requirement.

232.000 Rate Review Process**11-1-26**

A provider may request review of a Medicaid program rate policy or procedure by writing to the Assistant Director, Division of Medical Services. Refer to [Section I, 110.400](#) to get instructions for how to request a rate review.

242.100 Procedure Codes**11-1-26**

The table below contains procedure codes, the associated modifiers to be used with the individual code, and a description of each EPSDT service.

[View or print the procedure codes and modifiers for Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment \(EPSDT\) services.](#)

✱(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

Other coding information found in the chart:

¹ Exempt from PCP referral requirements

² Covered when specimen is referred to an independent lab

Electronic and paper claims require use of modifiers. When filing paper claims for a Child Health Services (EPSDT) screening service, the applicable modifier must be entered on the claim form.

See Section 212.000 for Child Health Services (EPSDT) screening terminology.

NOTES

- A. Arkansas Medicaid is no longer able to process both a sick visit and an EPSDT screening visit when performed on the same date of service without the appropriate modifier (Modifier 25). Modifier 25 must be indicated in the first position of the second billed service. This change surpasses the Medicaid policy to not bill modifiers on a sick visit when performed on the same date of service as an EPSDT screening.
- B. Newborn screenings can be performed by a Certified Nurse Midwife, Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner without a PCP referral.
- C. Procedure codes, used in conjunction with the **EP and H9 modifiers**, are to be used only for the required intake physical examination for Medicaid beneficiaries in the Arkansas foster care system. (See Section 214.300 for more information.)
- D. Claims for EPSDT medical screenings must be billed electronically or by using the CMS-1500 claim form. **May be billed on the CMS-1500 claim form, by paper or electronically.** ([View or print a CMS-1500 sample form.](#)) **May also be billed as EPSDT in the electronic transaction format or on the CMS-1500 paper form.**

- E. Laboratory/X-ray and immunizations associated with a Child Health Services (EPSDT) screen may be billed on the CMS-1500 claim form.
- F. Immunizations and laboratory tests may be billed separately from comprehensive screens.
- G. The verbal assessment of lead toxicity risk is part of the complete Child Health Services (EPSDT) screen. The cost for the administration of the risk assessment is included in the fee for the complete screen.
- H. May be used for billing in the office place of service (11) for the administration of subcutaneous or IM injections ONLY when the provider administers but does not supply the drug.
 - 1. Cannot be billed when the medication is administered orally. No fee is billable for drugs administered orally.
 - 2. Cannot be billed to administer any medication given for family planning purposes.
 - 3. Cannot be billed when the drug administered is not FDA approved.
- I. Procedure code is payable to physicians for supplies and materials (except eyeglasses), provided by the physician over and above those usually included with the office visit or other services rendered. The procedure code must not be billed for the provision of drug supply samples and may not be billed on the same date of service as a surgery code. Claims require National Place of Service code "11". The procedure code is limited to beneficiaries under age twenty-one (21).

SECTION II – CLINICAL NURSE SPECIALIST

CONTENTS

TOC required

200.000 CLINICAL NURSE SPECIALIST GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Clinical Nurse Specialist Program **11-1-26**

The Arkansas Medicaid Program enrolls clinical nurse specialists for participation in the Clinical Nurse Specialist Program. Clinical Nurse Specialist Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must be licensed by the state authority in the state in which services are furnished.
- B. The following documents must be submitted with the provider application and Medicaid contract:
 - 1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
 - 2. A provider of clinical nurse specialist's services (with the exception of those only providing services to pediatric beneficiaries) must be enrolled in the Title XVIII (Medicare) Program.
 - 3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures **11-1-26**

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Group Providers **11-1-26**

Group providers of Clinical Nurse Specialist services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

If a Clinical Nurse Specialist is a member of a group, each individual Clinical Nurse Specialist and the group must both enroll according to the following criteria:

- A. Each individual Clinical Nurse Specialist within the group must enroll following the criteria established in Section 201.000.
- B. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled, registered Clinical Nurse Specialist within the group.

201.200 Providers in Arkansas and Bordering States **11-1-26**

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

201.210 Providers in Non-Bordering States

11-1-26

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View or print the provider enrollment and contract package (Application Packet). View or print Provider Enrollment Unit Contact information.**

- B. Limited services providers remain enrolled for one year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly with the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Clinical Nurse Specialist

11-1-26

The registered Clinical Nurse Specialist must be certified as a registered Clinical Nurse Specialist by the state in which services are furnished.

Clinical Nurse Specialist must hold certification from a nationally recognized certifying body approved by the state in which services are furnished. Certification must be in the category and the specialty for which the clinical nurse specialist is educationally prepared.

202.000 Medical Records Clinical Nurse Specialists are Required to Keep

11-1-26

- A. Clinical Nurse Specialists are required to keep the following records and, upon request, furnish the records to authorized representatives of the Department of Human Services, the Office of Medicaid Inspector General; the state Medicaid Fraud Control Unit, representatives of the Centers for Medicare and Medicaid Services (CMS), and the U.S. Office of the Inspector General (OIG):

1. History and physical examinations;
2. Chief complaint on each visit;
3. Tests and results;
4. Diagnoses;
5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation;
6. Signature or initials of the Clinical Nurse Specialist after each visit;
7. Copies of records pertinent to all services delivered by the Clinical Nurse Specialist and billed to Medicaid; and

8. The service date of each service billed to Medicaid.
- B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards and the Arkansas Medicaid Provider Manual.
- C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.
- D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).
- E. All documentation must be made available to representatives of the appropriate organization during normal business hours at the time an audit is conducted. All documentation must be available at the provider's place of business.
- F. If an audit determines that recoupment is necessary, the provider has only sixty-five (65) days after the date of the recoupment letter to submit additional documentation for consideration. Additional documentation will not be accepted after the established deadline.

203.000 The Clinical Nurse Specialist's Role in Home Health Services 11-1-26

Clinical Nurse Specialists must meet the home health rules and regulations found in Section II of the Medicaid **Home Health Provider Manual**.

203.100 The Clinical Nurse Specialist's Role in the Pharmacy Program 11-1-26

Medicaid covers prescription drugs in accordance with rules and regulations set forth in Section II of the **Medicaid Pharmacy Provider manual** and pursuant to orders (prescriptions) from authorized prescribers. The Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements with the federal government.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. **View or print numeric listing of approved pharmaceutical companies and their respective labeler codes.** Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Clinical Nurse Specialist with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.101 Tamper Resistant Prescription Applications 11-1-26

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for "... amounts expended for medical assistance for covered outpatient drugs (as defined in section

1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad.” The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

See the Medicaid Tamper Resistant Prescription Law - Pharmacist Fact Sheet on the CMS website for technical information.

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

- A. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic, or compliant written prescription within seventy-two (72) hours after the date on which the prescription was filled; and
- B. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, “electronic prescriptions” include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated by a prescriber to the pharmacy by telephone.

203.200 The Clinical Nurse Specialist’s Role in the Child Health Services (EPSDT) Program

11-1-26

The Child Health Services Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their twenty-first (21st) birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services.

A primary care provider (PCP) may refer a child to a clinical nurse specialist to administer an EPSDT screen. A provider of clinical nurse specialist services may recommend to the PCP that an EPSDT screen could be necessary for any child that is thought to need one. If a clinical nurse specialist discovers a problem based on an EPSDT screen or receives a referral as a result of an EPSDT screen, clinical nurse specialist services may be provided after consulting with the child’s PCP. This does not prevent the clinical nurse specialist from choosing to enroll as a PCP and carrying a beneficiary caseload in the Medicaid PCCM program.

- A. Treatment means physician, physician assistant, nurse practitioner, certified nurse midwife, hearing, visual, dental, clinical nurse specialist services, and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.
- B. Clinical nurse specialists and other health professionals who administer Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.
- C. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires a treatment service not normally covered under the Arkansas Medicaid Program, the service will be considered for reimbursement if it is medically necessary and permitted under federal Medicaid regulations. **See Section 214.200 of the EPSDT manual** for how to request consideration of the services.

- D. Clinical Nurse Specialists may bill a sick visit and a periodic Child Health Services (EPSDT) screening for a patient on the same date of service. This visit must be billed electronically, or on paper using the CMS-1500 form. **View a CMS-1500 sample form.**

Refer to **Section I** of this manual for additional information. Providers of Child Health Services (EPSDT) should refer to the **Child Health Services (EPSDT) provider manual.**

203.300 The Clinical Nurse Specialist's Role in the ARKids First-B Program 11-1-26

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas's uninsured children. The primary care delivery network for ARKids First-B Program is ConnectCare, the Primary Care Provider (PCP) Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First-B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are like EPSDT screens. Except for routine newborn care, preventive health screens must be performed by the primary care provider (PCP) or referred by the PCP to an appropriate provider for screening. If a clinical nurse specialist receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP. Nothing in this section prohibits a Clinical Nurse Specialist from enrolling and serving as a primary care provider in the Arkansas Medicaid and ARKids First B program.

Clinical Nurse Specialists enrolled as a Medicaid provider and interested in participating in the **ARKids First-B program** can download the manual for further information.

203.400 Clinical Nurse Specialist's Role in Early Intervention Reporting for Children from Birth to Three Years of Age 11-1-26

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six (36) months of age. Health care providers offering any early intervention services to an eligible child must refer the child to the Arkansas Department of Education for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

- A. A child must be referred for early intervention if he or she is age birth to three (3) years and meets one (1) or more of the following criteria:

1. Developmental delay – a delay of twenty-five percent (25%) or greater in one (1) of the following areas of development:
 - a. Physical (gross or fine motor)
 - b. Cognitive
 - c. Communication
 - d. Social or emotional
 - e. Adaptive and self-help skills
2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
 - a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
 - b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly, and macrocephaly.
 - c. Maternal Acquired Immune Deficiency Syndrome (AIDS).

- d. Sensory impairments such as visual or hearing disorders.

The Arkansas Department of Education is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals can be made through **Refer A Child - Arkansas.gov**.

203.500 The Clinical Nurse Specialist's Role in Family Planning Services 11-1-26

Medicaid encourages reproductive health and family planning by providing a comprehensive range of family planning services through clinical nurse specialists and other providers. Medicaid beneficiaries' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

- A. Refer to Sections 214.321 through 214.333 of this manual for family planning coverage information.
- B. Refer to Sections 252.430 and 252.431 of this manual for family planning services special billing instructions and procedure codes.

203.600 The Clinical Nurse Specialist's Role in Hospital Services 11-1-26

- A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)
- B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a licensed clinical nurse specialist, a certified nurse-midwife, or a dentist with hospital staff privileges.
- C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program (MUMP). For critical access hospitals and acute crisis stays, DHS or its designated vendor reviews all inpatient stays longer than four (4) days.

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

- D. Hospital claims are subject to review by the Arkansas Medicaid Medical Director.
1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to clinical nurse specialists for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
 2. Clinical Nurse Specialists and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
 3. Clinical Nurse Specialists and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 The Clinical Nurse Specialist's Role in Preventing Program Abuse 11-1-26

- A. The Medicaid Program is responsible for assuring quality medical care for its beneficiaries and protecting the integrity of the public funds supporting the program.

The Department of Human Services is committed to this goal by providing staff and resources to the prevention, detection, and correction of abuse. However, this task can only be accomplished through the cooperation and support of the provider community. The clinical nurse specialist is often in a position to detect certain program abuses.

B. A clinical nurse specialist who suspects either beneficiary or provider abuse, or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will be conducted. **View or print the Arkansas Division of Medical Services Utilization Review Section contact information.**

C. Examples of the types of abuse you may detect include:

1. Beneficiary over-utilization of services;
2. Beneficiary misuse or inappropriate utilization of services;
3. Beneficiary misuse of I.D. card;
4. Poor quality of service; or
5. Provider over-utilization or abuse.

204.000 Role of Quality Improvement Organization (QIO)

11-1-26

The **Quality Improvement Organization (QIO)** reviews all federally and state funded hospital inpatient services, as well as some outpatient and professional services delivered by Medicaid enrolled providers. The purpose of such review is the promotion of effective, efficient, and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to ensure that federal payment for services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards, and provided in the most appropriate and least costly setting and location.

A pattern of unusual practice may result in a clinical nurse specialist having prepayment review of up to one hundred percent (100%) of admissions. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction

11-1-26

The Arkansas Medicaid and CHIP Programs are designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in **Section I of this manual**. All Medicaid and CHIP benefits are based upon medical necessity. **See the Glossary of this manual (Section IV) for the definition of “medical necessity”.**

212.000 Clinical Nurse Specialist

11-1-26

A clinical nurse specialist, as applicable to this program, is a licensed professional nurse who meets the participation requirements and enrollment criteria for advanced practice nursing defined by the state licensing authority.

The clinical nurse specialist provides direct care to individuals, families, and other groups in a variety of settings including homes, hospitals, nursing homes, offices, industries, schools, and other institutions and health care settings. The service provided by the clinical nurse specialist is directed toward the delivery of primary, secondary, and tertiary care that focuses on the achievement and maintenance of optimal functions in the population.

The clinical nurse specialist engages in independent decision-making about the health care needs of patients and collaborates with health professionals and others in making decisions about other health care needs. The clinical nurse specialist plans and initiates health care programs as a member of the health care team. The Clinical Nurse Specialist is directly accountable and responsible for the quality of care provided.

213.000 Scope**11-1-26**

The scope of the Clinical Nurse Specialist Program includes Medicaid covered services provided by pediatric, family, obstetric-gynecologic (women's health care), and gerontological nurse practitioners in accordance with state and federal regulations.

214.000 Coverage**11-1-26**

Many clinical nurse specialist services covered by the Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services that beneficiaries may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 and Section 252.484 for information about covered clinical nurse specialist services with restrictions, benefit limits, or both.

214.100 Exclusions**11-1-26**

Exclusions are those services not covered in the Medicaid Clinical Nurse Specialist Program and any covered services furnished by a clinical nurse specialist that are not within their scope of practice as defined by the state licensing authority and by the national certifying body. Services are not covered when provided by an employed or contracted clinical nurse specialist who is not enrolled in the Clinical Nurse Specialist Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented for diagnoses that certify medical necessity.

214.200 General Clinical Nurse Specialist Services**11-1-26**

A. Services provided by a clinical nurse specialist include initial visits and established patient visits for:

1. Diagnosis and evaluation
2. Treatment services
3. Health management services for prevention and early intervention
4. Appropriate referrals to other health care providers for diagnostic and treatment services

B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Clinical Nurse Specialist Services Benefit Limits**11-1-26**

A. For clients twenty-one (21) years of age or older, Clinical Nurse Specialist services provided in a physician office, an APRN office, a Clinical Nurse Specialist office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following other services are counted toward the Service Benefit Limits for Clinical Nurse Specialists:

1. APRN services in the office, patient's home, or nursing facility;
2. Physician services in the office, patient's home or nursing facility;
3. Rural health clinic (RHC) encounters;
4. Medical services furnished by a dentist;

5. Medical services furnished by an optometrist;
6. Certified nurse-midwife services in the office, patient's home or nursing facility;
7. Federally qualified health center (FQHC) encounters; and
8. Physician Assistant services.

The established benefit limit does not apply to clients under twenty-one (21) years of age.

Office visits are not counted toward the visit limit when one of the following is the primary diagnosis being treated: malignant Neoplasm, renal failure, HIV/AIDS, opioid use disorder when visits are part of a Medication Assisted Treatment (MAT) plan, and pregnancy.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.300 Reserved **11-1-26**

214.310 Reserved **11-1-26**

214.320 Reserved **11-1-26**

214.321 Family Planning Services for Women in Aid Category 61, PW **11-1-26**

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered services, including family planning services through the last day of the month in which the sixtieth (60th) day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 Family Planning Coverage Information **11-1-26**

- A. Medicaid encourages reproductive health and family planning by reimbursing clinical nurse specialists for a comprehensive range of family planning services.
 1. Family planning services do not require a PCP referral.
 2. Medicaid beneficiaries' family planning service benefits are in addition to their other medical benefits when providers bill the services specifically as family planning services.
 3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
 4. Extension of benefits is not available for family planning services.
 5. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Other than full coverage aid categories, Arkansas Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this Manual for service description and coverage information.
- C. Clinical Nurse Specialists desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 214.333 to Medicaid beneficiaries of childbearing age.
- D. Clinical Nurse Specialists preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local, and area providers qualified to provide family planning services. Listed providers include:
 1. Local Department of Health local health units;

2. Obstetricians and gynecologists;
3. Physicians and Physician Assistants;
4. Rural Health Clinics;
5. Federally Qualified Health Centers;
6. Family planning clinics;
7. Nurse Practitioners; and
8. Certified Nurse-Midwives.

E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Clinical Nurse Specialist Basic Family Planning Visit

11-1-26

Medicaid covers one (1) basic family planning visit per beneficiary per state fiscal year (July 1 through June 30). The basic family planning visit comprises the following:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight, and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam.
 2. The full range of contraceptive methods available.
 3. HIV and STI prevention.
- C. Prescription for any contraceptives selected by the beneficiary.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test.
 2. Hemoglobin and hematocrit.
 3. Sickle cell screening.
 4. Urinalysis testing for albumin and glucose.
 5. Papanicolaou (PAP) smears for cervical cancer.
 6. Testing for sexually transmitted infections.

214.332 Clinical Nurse Specialist Periodic Family Planning Visit

11-1-26

Medicaid covers three (3) periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure, laboratory services as identified in Section 214.331 (D), and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription, and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception

11-1-26

- A. Prescription and Non-Prescription Contraceptives:
 1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.

2. Medicaid covers non-prescription contraceptives as a family planning benefit when a qualified prescriber writes a prescription for them.

B. Contraceptive Implant Systems:

1. Medicaid covers the contraceptive implant systems as a family planning benefit, including implants and supplies.
2. Medicaid covers insertion, removal, and removal with reinsertion.

C. Intrauterine Device (IUD):

1. Medicaid pays for IUDs as a family planning benefit.
2. Medicaid reimburses providers who supply the IUD at the time of insertion.
3. Medicaid pays providers for IUD insertion and removal.

D. Medroxyprogesterone Acetate:

Medicaid covers medroxyprogesterone acetate injections for birth control as a family planning benefit.

E. Sterilization:

1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
2. Medicaid covers Occlusion by Placement of Permanent Implants. Coverage includes the procedure, the implant device, and follow-up procedures as specified in Section 252.430.
3. Refer to Sections 252.430 through 252.431 of this Manual for procedure codes and billing instructions for family planning services.

214.400 Reserved

11-1-26

214.500 Laboratory and X-Ray Services Referral Requirements

11-1-26

A clinical nurse specialist who refers a Medicaid beneficiary for laboratory, radiology, or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order*, pertinent supplemental diagnoses supporting the need for the test(s).

Clinical Nurse Specialists must meet the rules and regulations related to laboratory and X-Ray Services found in **Section II of the Medicaid Physician Provider Manual**.

214.600 Obstetrical Services

11-1-26

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Aid Category 62-PW-PE (Pregnant Women, Presumptively Eligible) receives prenatal services and services for conditions that may complicate the pregnancy. These services are limited to the outpatient setting only.

214.610 Covered Clinical Nurse Specialist Obstetrical Services

11-1-26

Covered clinical nurse specialist obstetrical services may be provided when medically necessary and are *limited* to antepartum and postpartum care. Appropriate referrals will be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High-Risk Pregnancy

11-1-26

A clinical nurse specialist may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a clinical nurse specialist does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment includes a medical, nutritional, and psychosocial assessment by a clinical nurse specialist or a registered nurse on the clinical nurse specialist's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form, includes:
 - a. Medical history;
 - b. Menstrual history; and
 - c. Pregnancy history.
2. Nutritional assessment includes:
 - a. 24-hour diet recall;
 - b. Screening for anemia; and
 - c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) assessment (units) per pregnancy

B. Case Management Services

Case management services are provided by a clinical nurse specialist, nurse practitioner, a licensed social worker, or registered nurse, to assist pregnant women eligible under Medicaid, in gaining access to needed medical, social, educational, and other services (examples include, but are not limited to, locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, and following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. A case management contact may be with the patient, other professionals, family, or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist, or health educator) include:

1. Pregnancy;
2. Labor and delivery;

3. Reproductive health;
4. Postpartum care;
5. Nutrition in pregnancy; and
6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan; and
2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) consultations (units) per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: Six (6) consultations (units) per pregnancy

E. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in Section 252.450.

214.700 Reserved

11-1-26

214.710 Inpatient Services

11-1-26

Clinical nurse specialist inpatient services must meet the Medicaid requirement of medical necessity. **The Quality Improvement Organization (QIO)** will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the clinical nurse specialist's supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Clinical nurse specialist claims and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

All medical staff must provide inpatient services in compliance with Section 6 of the **Arkansas State Board of Health Rules for Hospitals and Related Institutions in Arkansas.**

214.711 Medicaid Utilization Management Program (MUMP)

11-1-26

The Medicaid Utilization Management Program (MUMP) determines the covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Medicaid Program.

Clinical Nurse Specialists must meet the rules and regulations related to MUMP found in 224.200 – 224.400, **Section II of the Medicaid Physician Provider Manual.**

214.712 Evaluation and Management

11-1-26

- A. Medicaid covers clinical nurse specialist evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses clinical nurse specialists for medically necessary discharge day management unless the clinical nurse specialist evaluation and management services for that day are included in another service, or unless the clinical nurse specialist does not customarily bill private-pay patients for discharge day management.
- B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the clinical nurse specialist sees the patient.
- C. The Medicaid Program will recover payments to clinical nurse specialists for inpatient evaluation and management services on days when the hospital's inpatient claims are denied (or would be denied, if filed) for:
 - 1. Exceeding benefit limits;
 - 2. Failure to pre-certify inpatient days, when applicable; or
 - 3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures

11-1-26

Hospital reimbursement for inpatient services covered by Medicaid includes the non-professional components (technical components), such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to clinical nurse specialists and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of the machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed for diagnosing and treating an inpatient hospital beneficiary. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits

11-1-26

An annual benefit limit of twenty-four (24) medically necessary days per state fiscal year (July 1 through June 30) applies for Medicaid beneficiaries twenty-one (21) years of age and older. Once the beneficiary exhausts the twenty-four (24) day annual limit, reimbursement for any additional inpatient hospital days will be reduced to four hundred dollars (\$400) per day and is subject to recoupment if later determined not medically necessary.

Inpatient hospital benefit limits do not apply for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 11-1-26

Outpatient hospital clinical nurse specialist services are divided into two (2) types of service for the purpose of coverage and reimbursement determination: Emergency Services and Non-Emergency Services.

Emergency and non-emergency services are described in Sections 213.200 through 213.612 of the **Medicaid Hospital Provider Manual**

214.800 Occupational Therapy, Physical Therapy, and Speech-Language Pathology 11-1-26

Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as clinical nurse specialist services. Please refer to the **Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Manual** for rules, guidelines, and referral information related to this program.

214.900 Procedures for Obtaining Extension of Benefits 11-1-26

Clinical nurse specialists who perform diagnostic laboratory services, radiology, or other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 11-1-26

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting. Please refer to Section 229.100 through 229.130 of the **Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual** for information about requesting extension of benefits.

214.940 Administrative Reconsideration and Appeals 11-1-26

- 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**.

214.950 Reserved 11-1-26

214.952 Continued Services During the Appeal Process 11-1-26

Services may be continued pending the outcome of an appeal in accordance with Section 161.500 of this Manual.

215.000 Fluoride Varnish Treatment 11-1-26

Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at <http://ar.train.org>. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization 11-1-26

- A. Certain medical and surgical services are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.
- B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical services covered by the Arkansas Medicaid Program. **[View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.](#)**
 - 1. Prior authorization determinations are made in accordance with established medical or administrative criteria as determined in the professional judgment of physician advisors to Arkansas Medicaid.
 - 2. Payment for prior-authorized services is in accordance with federal regulations.
- C. Prior authorization of service does not guarantee payment of a service. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided; and that services are provided and billed in accordance with the prior authorization issued.

221.100 Post-Procedural Authorization for Beneficiaries Age 21 and Older 11-1-26

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age and older. Requests for post-procedural authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-procedural authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 11-1-26

- A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.
- B. The following process must be followed when obtaining a post-procedural authorization number.
 - 1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. **[View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.](#)**
 - 2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **[View or print contact information to obtain dates of eligibility.](#)**

3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization

11-1-26

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a clinical nurse specialist with prescriptive authority. Certain prescription drugs may require prior authorization. The prescriber is responsible for requesting and obtaining the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

The following information is available at the **DHS contracted Pharmacy Vendors website**:

- A. Prescription drugs requiring prior authorization.
- B. Criteria for drugs requiring prior authorization.
- C. Forms to be completed for prior authorization.
- D. Procedures required of the prescriber to request and obtain prior authorization.

221.300 Procedures in the Outpatient Setting

11-1-26

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement

11-1-26

Medicaid reimbursement for clinical nurse specialist services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules

11-1-26

Arkansas Medicaid provides **fee schedules on the Arkansas Medicaid Division of Medical Services website**. The fees represent the fee- for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage, or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid reimburses the lesser of the amount billed or the Medicaid maximum fee schedule amount.

232.000 Rate Review Process

11-1-26

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to **Section I, 110.400** of the manual to get instructions for requesting a review.

250.000 BILLING PROCEDURES**251.000 Introduction to Billing 11-1-26**

Clinical nurse specialist providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures 11-1-26**252.100 Reserved 11-1-26****252.110 Billing Protocol for Computed Tomographic Colonography (CT) 11-1-26**

- A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

- B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Clinical Nurse Specialist, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved 11-1-26**252.130 Special Billing Instructions 11-1-26**

- A. Use the following procedure codes for billing.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services

- B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by the unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must also be met for payment to be approved.

252.131 Molecular Pathology 11-1-26

The following Molecular Pathology codes require prior authorization from DHS or its designated QIO contractor. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services

252.132 Special Billing Requirements for Lab and X-Ray Services 11-1-26

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

- A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code.
- B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

All other billing requirements must also be met for payment to be approved.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services

252.200 Reserved

11-1-26

252.210 National Place of Service (POS) Codes

11-1-26

Electronic and paper claims now require the same National Place of Service code. Clinical Nurse Specialists may provide services in the following locations:

<u>Place of Service</u>	<u>POS Codes</u>
<u>Inpatient Hospital</u>	<u>21</u>
<u>Outpatient Hospital</u>	<u>22</u>
<u>Office</u>	<u>11</u>
<u>Patient's Home</u>	<u>12</u>
<u>Mobile Unit</u>	<u>15</u>
<u>Nursing Facility</u>	<u>32</u>
<u>Skilled Nursing Facility</u>	<u>31</u>
<u>Ambulance</u>	<u>41</u>
<u>Other Locations</u>	<u>99</u>
<u>Telehealth</u>	<u>02</u>
<u>Telehealth in Home</u>	<u>10</u>

252.300 Billing Instructions – Paper Claims Only

11-1-26

Bill Medicaid for clinical nurse specialist services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if required information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form

11-1-26

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message, contact, emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
d. <u>INSURANCE PLAN</u> <u>NAME OR</u> <u>PROGRAM</u> <u>NAME</u>	<u>Name of the insurance company.</u>
10. <u>IS PATIENT'S CONDITION</u> <u>RELATED TO:</u>	
a. <u>EMPLOYMENT?</u> <u>(Current or</u> <u>Previous)</u>	<u>Check YES or NO.</u>
b. <u>AUTO ACCIDENT?</u> <u>PLACE (State)</u>	<u>Required when an auto accident is related to the</u> <u>services. Check YES or NO.</u> <u>If 10b is YES, the two-letter postal abbreviation for the</u> <u>state in which the automobile accident took place.</u>
c. <u>OTHER</u> <u>ACCIDENT?</u>	<u>Required when an accident other than automobile is</u> <u>related to the services. Check YES or NO.</u>
d. <u>CLAIM CODES</u>	<u>The "Claim Codes" identify additional information about</u> <u>the beneficiary's condition or the claim. When</u> <u>applicable, use the Claim Code to report appropriate</u> <u>claim codes as designated by the NUCC. When required</u> <u>to provide the subset of Condition Codes, enter the</u> <u>condition code in this field. The subset of approved</u> <u>Condition Codes is found at www.nucc.org under Code</u> <u>Sets.</u>
11. <u>INSURED'S POLICY</u> <u>GROUP OR FECA</u> <u>NUMBER</u>	<u>Not required when Medicaid is the only payer.</u>
a. <u>INSURED'S DATE</u> <u>OF BIRTH</u> <u>SEX</u>	<u>Not required.</u> <u>Not required.</u>
b. <u>OTHER CLAIM ID</u> <u>NUMBER</u>	<u>Not required.</u>
c. <u>INSURANCE PLAN</u> <u>NAME OR</u> <u>PROGRAM NAME</u>	<u>Not required.</u>
d. <u>IS THERE</u> <u>ANOTHER HEALTH</u> <u>BENEFIT PLAN?</u>	<u>When private or other insurance may or will cover any of</u> <u>the services, check YES and complete items 9, 9a and</u> <u>9d. Only one box can be marked.</u>
12. <u>PATIENT'S OR</u> <u>AUTHORIZED PERSON'S</u> <u>SIGNATURE</u>	<u>Enter "Signature on File," "SOF" or legal signature.</u>
13. <u>INSURED'S OR</u> <u>AUTHORIZED PERSON'S</u> <u>SIGNATURE</u>	<u>Enter "Signature on File," "SOF" or legal signature.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
14. <u>DATE OF CURRENT:</u> <u>ILLNESS (First symptom)</u> <u>OR</u> <u>INJURY (Accident) OR</u> <u>PREGNANCY (LMP)</u>	<u>Required when services furnished are related to an accident, whether the accident is recent or in the past.</u> <u>Date of the accident.</u> <u>Enter the qualifier to the right of the vertical dotted line.</u> <u>Use Qualifier 431 Onset of Current Symptoms or Illness;</u> <u>484 Last Menstrual Period.</u>
15. <u>OTHER DATE</u>	<u>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</u> <u>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</u> <u>454 Initial Treatment</u> <u>304 Latest Visit or Consultation</u> <u>453 Acute Manifestation of a Chronic Condition</u> <u>439 Accident</u> <u>455 Last X-Ray</u> <u>471 Prescription</u> <u>090 Report Start (Assumed Care Date)</u> <u>091 Report End (Relinquished Care Date)</u> <u>444 First Visit or Consultation</u>
16. <u>DATES PATIENT UNABLE</u> <u>TO WORK IN CURRENT</u> <u>OCCUPATION</u>	<u>Not required.</u>
17. <u>NAME OF REFERRING</u> <u>PROVIDER OR OTHER</u> <u>SOURCE</u>	<u>Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.</u>
17a. (blank)	<u>Not required.</u>
17b. NPI	<u>Enter NPI of the referring physician.</u>
18. <u>HOSPITALIZATION DATES</u> <u>RELATED TO CURRENT</u> <u>SERVICES</u>	<u>When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.</u>
19. <u>ADDITIONAL CLAIM</u> <u>INFORMATION</u>	<u>Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.</u>
20. <u>OUTSIDE LAB?</u>	<u>Not required.</u>
<u>\$ CHARGES</u>	<u>Not required.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
21. <u>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</u>	<u>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</u> <u>Use "9" for ICD-9-CM</u> <u>Use "0" for ICD-10-CM.</u> <u>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</u> <u>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</u>
22. <u>RESUBMISSION CODE</u> <u>ORIGINAL REF. NO.</u>	<u>Reserved for future use.</u> <u>Any data or other information listed in this field does not and will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.</u>
23. <u>PRIOR AUTHORIZATION NUMBER</u>	<u>The prior authorization or benefit extension control number if applicable.</u>
24A. <u>DATE(S) OF SERVICE</u>	<u>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</u> <u>1. On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month.</u> <u>2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.</u>
B. <u>PLACE OF SERVICE</u>	<u>Two-digit national standard place of service code. See Section 292.200 for codes.</u>
C. <u>EMG</u>	<u>Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</u>
D. <u>PROCEDURES, SERVICES, OR SUPPLIES</u> <u>CPT/HCPCS</u> <u>MODIFIER</u>	<u>Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.</u> <u>Modifier(s) if applicable.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
<u>E. DIAGNOSIS POINTER</u>	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
<u>F. \$ CHARGES</u>	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
<u>G. DAYS OR UNITS</u>	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
<u>H. EPSDT/Family Plan</u>	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
<u>I. ID QUAL</u>	Not required.
<u>J. RENDERING PROVIDER ID #</u>	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
<u>NPI</u>	Enter NPI of the individual who furnished the services billed for in the detail.
<u>25. FEDERAL TAX I.D. NUMBER</u>	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
<u>26. PATIENT'S ACCOUNT NO.</u>	Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
<u>27. ACCEPT ASSIGNMENT?</u>	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
<u>28. TOTAL CHARGE</u>	Total of Column 24F—the sum all charges on the claim.
<u>29. AMOUNT PAID</u>	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
<u>30. RESERVED</u>	Reserved for NUCC use.
<u>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</u>	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
<u>32. SERVICE FACILITY LOCATION INFORMATION</u>	<u>If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.</u>
<u>a. (blank)</u>	<u>Not required.</u>
<u>b. (blank)</u>	<u>Not required.</u>
<u>33. BILLING PROVIDER INFO & PH #</u>	<u>Billing provider's name and complete address. Telephone number is requested but not required.</u>
<u>a. (blank)</u>	<u>Enter NPI of the billing provider or</u>
<u>b. (blank)</u>	<u>Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.</u>

252.400 Special Billing Procedures **11-1-26**

252.410 Clinic or Group Billing **11-1-26**

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) clinical nurse specialist in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.420 Evaluations and Management **11-1-26**

252.421 Initial Visit **11-1-26**

The American Medical Association's *Current Procedures Terminology (CPT)* codes for a new patient should be used only for the first visit. Each subsequent visit should be billed using a CPT code denoting an established patient for office visits, home visits, nursing facility, visits, and emergency room visits. Refer to the latest edition of the CPT manual for detailed information.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service) **11-1-26**

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Procedure code must be used by clinical nurse specialists when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

252.423 Inpatient Hospital Visits **11-1-26**

Each clinical nurse specialist is limited to billing one (1) day of care for each inpatient hospital covered day, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management

11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits

11-1-26

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in a nursing facility.

252.426 Specimen Collections

11-1-26

The policy regarding collection, handling and conveyance of specimens is:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in the following circumstances : (1) drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.428 Services Not Considered a Separate Service from an Office Visit

11-1-26

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Specific procedure codes should never be used for billing routine pelvic examinations but should be used only when a pelvic examination is done under general anesthesia.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.429 Health Examinations for ARKids First B Beneficiaries and Medicaid Beneficiaries Under Age 21

11-1-26

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes

11-1-26

- A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures.** Laboratory procedure codes covered for family planning are listed in Section 252.431.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, nurse practitioner, clinical nurse specialists, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, assistant surgeon, and other appropriate providers.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) may result in the delay or denial of payment for the sterilization procedures. The checklist on DMS-615 lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**

- C. The following procedure code table explains the family planning visit procedure codes and modifiers; laboratory procedure codes and modifiers; and pathology procedure codes and modifiers payable to clinical nurse specialists.

NOTE: The procedure codes with the modifiers denote the Arkansas Medicaid description.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

The FP modifier is used on the claim to indicate the procedure code is for family planning services.

If a procedure code is marked with a single asterisk, (*), bill using modifiers FP, SA.

If a venous blood specimen is marked with a double asterisk, (**), reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Modifier FP for family planning services must be entered on the claim.

Family planning laboratory codes are found in Section 252.431.

252.431 Family Planning Laboratory Procedure Codes**11-1-26**

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW) For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

- A. The following procedure code table contains family planning laboratory procedure codes.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

αSee points B and C below for information regarding this procedure code.

B. Laboratory codes payable to non-hospital-based clinical nurse specialists.

The following procedure code table contains laboratory services payable to non-hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

C. Laboratory codes payable to hospital-based clinical nurse specialists.

The following procedure code table describes the laboratory services payable to hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

252.438 National Drug Codes (NDCs) 11-1-26

The Federal Deficit Reduction Act of 2005 mandates the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for drugs administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

Clinical Nurse Specialists must meet the rules and regulations related to NDCs found in 292.910 of Section II of the Medicaid Physician Provider Manual.

252.440 Reserved 11-1-26**252.441 Family/Group Psychotherapy 11-1-26**

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes 11-1-26

The technical component radiology procedure codes listed on the Clinical Nurse Specialist fee schedule are payable when performed in the office place of service (11) if the clinical nurse specialist provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Clinical Nurse Specialist fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Clinical nurse specialist providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections 11-1-26

Clinical nurse specialists billing the Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the

specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code (“Z code”) are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can only be billed on a paper claim. When only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 11-1-26

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved 11-1-26

252.446 Reserved 11-1-26

252.447 Reserved 11-1-26

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment 11-1-26
Drugs

Effective for dates of service on and after September 1, 2020, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries . All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after October 1, 2018, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website.**

252.449 Influenza Virus Vaccine**11-1-26****View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.**

- A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

- B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for three (3) years of age and older.
1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. For individuals nineteen (19) years of age and older, no modifier is necessary.
- C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals who are five through forty-nine (5-49) years of age and who are not pregnant.
1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.
- D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.
- For ARKids First-B beneficiaries, use modifier **TJ**.
- E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.
1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy**11-1-26**

Covered clinical nurse specialist obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A clinical nurse specialist may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the clinical nurse specialist employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered as one (1) service and are limited to thirty-two (32) cumulative units.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.452 Newborn Care

11-1-26

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn are responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) are responsible for the charges incurred by the newborn.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, clinical nurse specialist.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500 form; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **[View or print Provider Assistance Center contact information.](#)**

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment

11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

The American Dental Association (ADA) procedure code is covered by the Medicaid Program. This code is payable for beneficiaries under twenty-one (21) years of age. Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification, will be tied to provider types 01, 03, 58, and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code can be added to their file in the MMIS. **[View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.](#)** After the FC-Fluoride Certification specialty code is added to the provider's file, the provider will be able to bill the procedure code for Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is

needed due to severe periodontal disease, the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services

11-1-26

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products, either prescribed or initiated through statewide pharmacist protocol, are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the DHS Contracted Pharmacy Vendor website or in the Prescription Drug Program Prior Authorization Criteria.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

*Exempt from PCP referral requirements.

* (...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Two (2) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, they can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit.
View or print a copy of the checklist: Be Well Arkansas Referral Form.

252.455 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services

11-1-26

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the clinical nurse specialist. Physical therapy may be payable to the physician when directly provided according to the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See **Glossary - Section IV** - for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for beneficiaries of all ages for medically necessary physical and speech therapy.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 11-1-26

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.457 Procedures That Require Prior Authorization 11-1-26

- A. The following procedure code requires prior authorization by DHS or its designated contractor. (See Section 220.000 of this manual for prior authorization instructions.)
- B. The following Molecular Pathology codes require prior authorization from DHS or its designated contractor.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.458 Substitute Clinical Nurse Specialist 11-1-26

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements to adhere to **locum tenens clinical nurse specialist** and **substitute clinical nurse specialist** billing and coverage policies and procedures.

A. Description of Service

Locum tenens and substitute clinical nurse specialist are terms used to describe the relationship of a clinical nurse specialist who is acting as a fill-in for a beneficiary's regular clinical nurse specialist. The regular clinical nurse specialist could be a specialist the beneficiary sees regularly for a chronic condition or a specific problem. A locum tenens or substitute clinical nurse specialist must be the same discipline as the clinical nurse specialist. Documentation of the locum tenens arrangement must include the services provided, the date the services were performed, and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

B. Substitute Clinical Nurse Specialist

A substitute clinical nurse specialist is a clinical nurse specialist who is asked by the regular clinical nurse specialist to see a beneficiary in a reciprocal arrangement when the regular clinical nurse specialist is unavailable to see the beneficiary. In the substitute clinical nurse specialist arrangement, the regular clinical nurse specialist reciprocates the substitute clinical nurse specialist by paying the substitute the amount received for the service rendered or by serving in the same capacity in return. For this provision to occur, both the regular and the substitute clinical nurse specialist must be enrolled in Arkansas Medicaid.

The following billing protocol must be utilized for substitute clinical nurse specialist circumstances:

1. The regular clinical nurse specialist office submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute clinical nurse specialist.

3. The substitute clinical nurse specialist arrangement should not exceed fourteen (14) consecutive days. The substitute clinical nurse specialist arrangement does not apply to substitution for clinical nurse specialists in the same medical group with claims submitted in the name of the medical group. (For situations in which a group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Clinical Nurse Specialists

A locum tenens arrangement is made when the regular clinical nurse specialist must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. The locum tenens clinical nurse specialist usually has no practice of his or her own and moves from area to area as needed. The clinical nurse specialist is usually paid a fixed amount per diem with the status of an independent contractor, not an employee. The locum tenens clinical nurse specialist must meet all state, hospital, and other institutional credentialing requirements. The locum tenens clinical nurse specialist is required to be enrolled in Arkansas Medicaid.

Documentation of the locum tenens arrangement must include the services provided by the locum tenens and when those services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

The following billing protocol must be utilized for locum tenens clinical nurse specialist circumstances:

1. The regular clinical nurse specialist's office submits their claims for locum tenens services using the regular nurse practitioner's provider identification number.
2. Modifier Q6 is placed in the indicator 24D of the CMS-1500 claim form to indicate services were provided by a locum tenens clinical nurse specialist. The payment amount is the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
3. Locum tenens arrangements should not exceed sixty (60) days. If a clinical nurse specialist is away more than sixty (60) days, additional locum tenens can be used to fill in for different sixty (60) day periods. This means that various clinical nurse specialists would be required to fill in for different sixty (60) day time periods. Locum tenens is not designed to fill clinical nurse specialist vacancies within the practice.

Exception: In accordance with Public Law 110-173, the exception to the sixty (60) day limit on substitute clinical nurse specialist billing occurs when a clinical nurse specialist is ordered to active military duty in the Armed Forces.

See the table below which compares the requirements for substitute and locum tenens clinical nurse specialists according to Arkansas Medicaid Policy.

<u>REQUIREMENT</u>	<u>SUBSTITUTE Clinical Nurse Specialist</u>	<u>LOCUM TENENS Clinical Nurse Specialist</u>
<u>Must be enrolled as an Arkansas Medicaid Provider</u>	<u>Yes</u>	<u>Yes</u>
<u>May be enrolled by the same group as the regular clinical nurse specialist</u>	<u>No</u>	<u>No</u>
<u>Claims are submitted by the regular clinical nurse specialist's office and that office receives payment</u>	<u>Yes</u>	<u>Yes</u>
<u>Modifier required to identify arrangement</u>	<u>Yes, Q5</u>	<u>Yes, Q6</u>
<u>May use the regular clinical nurse specialist's certification code for PCP authorization</u>	<u>Yes</u>	<u>Yes</u>
<u>Maximum time frame allowed</u>	<u>14 days</u>	<u>60 days</u>

252.460 Outpatient Hospital Services **11-1-26**

252.461 Emergency Services **11-1-26**

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in an outpatient hospital setting for emergency services.

252.462 Non-Emergency Services **11-1-26**

Procedure code should be billed for a non-emergency clinical nurse specialist visit.

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.

252.463 Outpatient Hospital Surgical Procedures **11-1-26**

For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by the unlisted code. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met for payment to be approved.

252.464 Multiple Surgery **11-1-26**

If multiple surgical procedures are done on the same date of service, but not in the same operative session, each should be coded in the "Procedures, Services or Supplies" field as a separate procedure.

252.465 Observation Status **11-1-26**

When claims are filed for services provided to a patient in "observation status," clinical nurse specialists must adhere to Medicaid definitions of inpatient and outpatient.

Observation status is an outpatient designation. Clinical Nurse Specialists must also follow the guidelines and definitions in Current Procedural Terminology (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

- A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the clinical nurse specialist should consider the patient an outpatient (meaning the patient is an outpatient unless the clinical nurse specialist's supervising physician has admitted them as an inpatient).
- B. If the clinical nurse specialist or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the clinical nurse specialist's supervising physician has not yet formally admitted the patient.
- C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for twenty-four (24) consecutive hours, even if the clinical nurse specialist's supervising physician or hospital had no prior expectation of a stay of that or greater duration.

252.466 Billing Examples**11-1-26**

The following table gives examples of appropriate clinical nurse specialist claims for several common hospital scenarios. In the table, instructions under the headings "CLINICAL NURSE SPECIALIST MAY BILL..." do not necessarily include all services that the clinical nurse specialist may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

ARKANSAS MEDICAID OBSERVATION STATUS POLICY ILLUSTRATION

<u>PATIENT IS ADMITTED TO OBSERVATION</u>	<u>PATIENT IS</u>	<u>CLINICAL NURSE SPECIALIST MAY BILL FOR TUESDAY SERVICES:</u>	<u>CLINICAL NURSE SPECIALIST MAY BILL FOR WEDNESDAY SERVICES:</u>
<u>Tuesday, 3:00 PM</u>	<u>Still in Observation Wednesday, 3:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Appropriate level of Initial Hospital Care</u>
<u>Tuesday, 3:00 PM</u>	<u>Discharged Wednesday, 12:00 PM (noon)</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Observation care Discharge Day Management</u>
<u>Tuesday, 3:00 PM</u>	<u>Discharged Wednesday, 4:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Appropriate level of Initial Hospital Care</u>
<u>Tuesday, 3:00 PM, after outpatient surgery</u>	<u>Discharged Wednesday, 10:00 AM</u>	<u>Outpatient surgery</u>	<u>No evaluation and Management Services</u>
<u>Tuesday, 3:00 PM, after exam in Emergency Department— emergency or non- emergency</u>	<u>Discharged Tuesday, 7:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Not Applicable; Patient was Discharged Tuesday</u>

252.470 Prior Authorization Control Number**11-1-26**

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare**11-1-26**

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement**11-1-26**

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information.**

These services can usually be filed electronically unless they are covered by Medicare and the beneficiary was sixty-five (65) or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims so they may receive special handling.

252.482 Services Not Medicare Approved**11-1-26**

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare but are covered by Medicaid. These are exceptions and may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS**11-1-26**

- A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:
 - 1. Pediatric acute-onset neuropsychiatric syndrome (PANS).
 - 2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).
- B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).
- C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:
 - 1. The drug treatment must be authorized under a Treatment Plan; and
 - 2. The Treatment Plan must be established by the approved PANS/PANDAS provider.
- D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. **View or print contact information for the QIO.**
- E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services, including PANS and PANDAS procedure codes.

252.484 Injections, Therapeutic, and Diagnostic Agents**11-1-26**

Clinical nurse specialists shall administer injections, therapeutic, and diagnostic agents according to the rules set forth in the Medicaid Physician's policy manual and within the scope of their practice guidelines. **View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.**

MARK-UP

SECTION II – CLINICAL NURSE SPECIALIST CONTENTS

TOC required

200.000 CLINICAL NURSE SPECIALIST GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Clinical Nurse Specialist Program 11-1-26

The Arkansas Medicaid Program enrolls clinical nurse specialists for participation in the Clinical Nurse Specialist Program. Clinical Nurse Specialist Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must be licensed by the state authority in the state in which services are furnished.
- B. The following documents must be submitted with the provider application and Medicaid contract:
 1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
 2. A provider of clinical nurse specialist's services (with the exception of those only providing services to pediatric beneficiaries) must be enrolled in the Title XVIII (Medicare) Program.
 3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures 11-1-26

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Group Providers 11-1-26

Group providers of Clinical Nurse Specialist services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program.

If a Clinical Nurse Specialist is a member of a group, each individual Clinical Nurse Specialist and the group must both enroll according to the following criteria:

- A. Each individual Clinical Nurse Specialist within the group must enroll following the criteria established in Section 201.000.
- B. All group providers are "pay to" providers only. The service must be performed and billed by a Medicaid-enrolled, registered Clinical Nurse Specialist within the group.

201.200 Providers in Arkansas and Bordering States 11-1-26

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

201.210 Providers in Non-Bordering States

11-1-26

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\)](#). [View or print Provider Enrollment Unit Contact information](#).

- B. Limited services providers remain enrolled for one year.
1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
 2. During the enrollment period, the provider may file any subsequent claims directly with the Medicaid fiscal agent.
 3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Clinical Nurse Specialist

11-1-26

The registered Clinical Nurse Specialist must be certified as a registered Clinical Nurse Specialist by the state in which services are furnished.

Clinical Nurse Specialist must hold certification from a nationally recognized certifying body approved by the state in which services are furnished. Certification must be in the category and the specialty for which the clinical nurse specialist is educationally prepared.

202.000 Medical Records Clinical Nurse Specialists are Required to Keep

11-1-26

- A. Clinical Nurse Specialists are required to keep the following records and, upon request, furnish the records to authorized representatives of the Department of Human Services, the Office of Medicaid Inspector General; the state Medicaid Fraud Control Unit, representatives of the Centers for Medicare and Medicaid Services (CMS), and the U.S. Office of the Inspector General (OIG):
1. History and physical examinations;
 2. Chief complaint on each visit;
 3. Tests and results;
 4. Diagnoses;
 5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation;
 6. Signature or initials of the Clinical Nurse Specialist after each visit;
 7. Copies of records pertinent to all services delivered by the Clinical Nurse Specialist and billed to Medicaid; and

8. The service date of each service billed to Medicaid.
- B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards and the Arkansas Medicaid Provider Manual.
- C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.
- D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).
- E. All documentation must be made available to representatives of the appropriate organization during normal business hours at the time an audit is conducted. All documentation must be available at the provider's place of business.
- F. If an audit determines that recoupment is necessary, the provider has only sixty-five (65) days after the date of the recoupment letter to submit additional documentation for consideration. Additional documentation will not be accepted after the established deadline.

203.000 The Clinical Nurse Specialist's Role in Home Health Services 11-1-26

Clinical Nurse Specialists must meet the home health rules and regulations found in Section II of the Medicaid [Home Health Provider Manual](#).

203.100 The Clinical Nurse Specialist's Role in the Pharmacy Program 11-1-26

Medicaid covers prescription drugs in accordance with rules and regulations set forth in Section II of the [Medicaid Pharmacy Provider manual](#) and pursuant to orders (prescriptions) from authorized prescribers. The Medicaid Program complies with the Medicaid Prudent Pharmaceutical Purchasing Program (MPPPP) which was enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990. **This law requires Medicaid to limit coverage to drugs manufactured by pharmaceutical companies that have signed rebate agreements with the federal government.** A numeric listing of approved pharmaceutical companies and their respective labeler codes is located on the Arkansas Division of Medical Services (DMS) Pharmacy website. [View or print numeric listing of approved pharmaceutical companies and their respective labeler codes](#). Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Clinical Nurse Specialist with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. [View or print contact information for the DHS designated Pharmacy Vendor](#).

203.101 Tamper Resistant Prescription Applications 11-1-26

Section 7002(b), which amends section 1903(i) of the Social Security Act (the Act) (42 U.S.C. section 1936b(i)) by adding new paragraph (23), states that payment shall not be made for "... amounts expended for medical assistance for covered outpatient drugs (as defined in section

1927(k)(2) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad.” The tamper-resistant pad requirement of section 7002(b) applies to all outpatient drugs, including over-the-counter drugs in States that reimburse for prescriptions for such items. Section 7002(b) is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

[See the Medicaid Tamper Resistant Prescription Law - Pharmacist Fact Sheet on the CMS website for technical information.](#)

Regardless of whether Medicaid is the primary or secondary payer of the prescription being filled, this rule applies to all non-electronic Medicaid-covered outpatient drugs except:

- A. Emergency fills of non-controlled or controlled dangerous substances for which a prescriber provides the pharmacy with a verbal, faxed, electronic, or compliant written prescription within seventy-two (72) hours after the date on which the prescription was filled; and
- B. Drugs provided in nursing facilities, intermediate care facilities for individuals with intellectual disabilities and other federally specified institutional and clinical settings so long as those drugs are not billed separately to Medicaid, for example, those billed by an individual pharmacy provider.

For purposes of this rule, “electronic prescriptions” include e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy, or prescriptions communicated by a prescriber to the pharmacy by telephone.

203.200 The Clinical Nurse Specialist’s Role in the Child Health Services (EPSDT) Program

11-1-26

The [Child Health Services Early Periodic Screening, Diagnosis and Treatment \(EPSDT\) program](#) is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their twenty-first (21st) birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care, including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services.

A primary care provider (PCP) may refer a child to a clinical nurse specialist to administer an EPSDT screen. A provider of clinical nurse specialist services may recommend to the PCP that an EPSDT screen could be necessary for any child that is thought to need one. If a clinical nurse specialist discovers a problem based on an EPSDT screen or receives a referral as a result of an EPSDT screen, clinical nurse specialist services may be provided after consulting with the child’s PCP. This does not prevent the clinical nurse specialist from choosing to enroll as a PCP and carrying a beneficiary caseload in the Medicaid PCCM program.

- A. Treatment means physician, physician assistant, nurse practitioner, certified nurse midwife, hearing, visual, dental, clinical nurse specialist services, and any other type of medical care and services recognized under State law to prevent or correct disease or abnormalities detected by screening or by diagnostic procedures.
- B. Clinical nurse specialists and other health professionals who administer Child Health Services (EPSDT) screening may diagnose and treat health problems discovered during the screening or may refer the child to other appropriate sources for treatment.
- C. If a condition is diagnosed through a Child Health Services (EPSDT) screen that requires a treatment service not normally covered under the Arkansas Medicaid Program, the service will be considered for reimbursement if it is medically necessary and permitted under federal Medicaid regulations. [See Section 214.200 of the EPSDT manual](#) for how to request consideration of the services.

- D. Clinical Nurse Specialists may bill a sick visit and a periodic Child Health Services (EPSDT) screening for a patient on the same date of service. This visit must be billed electronically, or on paper using the CMS-1500 form. [View a CMS-1500 sample form.](#)

Refer to [Section I](#) of this manual for additional information. Providers of Child Health Services (EPSDT) should refer to the [Child Health Services \(EPSDT\) provider manual](#).

203.300 The Clinical Nurse Specialist's Role in the ARKids First-B Program 11-1-26

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas's uninsured children. The primary care delivery network for ARKids First-B Program is ConnectCare, the Primary Care Provider (PCP) Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First-B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are like EPSDT screens. Except for routine newborn care, preventive health screens must be performed by the primary care provider (PCP) or referred by the PCP to an appropriate provider for screening. If a clinical nurse specialist receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP. Nothing in this section prohibits a Clinical Nurse Specialist from enrolling and serving as a primary care provider in the Arkansas Medicaid and ARKids First B program.

Clinical Nurse Specialists enrolled as a Medicaid provider and interested in participating in the [ARKids First-B program](#) can download the manual for further information.

203.400 Clinical Nurse Specialist's Role in Early Intervention Reporting for Children from Birth to Three Years of Age 11-1-26

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six (36) months of age. Health care providers offering any early intervention services to an eligible child must refer the child to the Arkansas Department of Education for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

- A. A child must be referred for early intervention if he or she is age birth to three (3) years and meets one (1) or more of the following criteria:
1. Developmental delay – a delay of twenty-five percent (25%) or greater in one (1) of the following areas of development:
 - a. Physical (gross or fine motor)
 - b. Cognitive
 - c. Communication
 - d. Social or emotional
 - e. Adaptive and self-help skills
 2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
 - a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
 - b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly, and macrocephaly.
 - c. Maternal Acquired Immune Deficiency Syndrome (AIDS).

- d. Sensory impairments such as visual or hearing disorders.

The Arkansas Department of Education is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals can be made through [Refer A Child - Arkansas.gov](https://www.arkansas.gov).

203.500 The Clinical Nurse Specialist's Role in Family Planning Services 11-1-26

Medicaid encourages reproductive health and family planning by providing a comprehensive range of family planning services through clinical nurse specialists and other providers. Medicaid beneficiaries' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

- A. Refer to Sections 214.321 through 214.333 of this manual for family planning coverage information.
- B. Refer to Sections 252.430 and 252.431 of this manual for family planning services special billing instructions and procedure codes.

203.600 The Clinical Nurse Specialist's Role in Hospital Services 11-1-26

- A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)
- B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed nurse practitioner, a licensed clinical nurse specialist, a certified nurse-midwife, or a dentist with hospital staff privileges.
- C. DHS or its designated vendor reviews all inpatient hospital transfers and all inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program (MUMP). For critical access hospitals and acute crisis stays, DHS or its designated vendor reviews all inpatient stays longer than four (4) days.

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.](#)

- D. Hospital claims are subject to review by the Arkansas Medicaid Medical Director.
 - 1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to clinical nurse specialists for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
 - 2. Clinical Nurse Specialists and hospitals may not bill a Medicaid beneficiary for a service Medicaid has declared not medically necessary.
 - 3. Clinical Nurse Specialists and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 The Clinical Nurse Specialist's Role in Preventing Program Abuse 11-1-26

- A. The Medicaid Program is responsible for assuring quality medical care for its beneficiaries and protecting the integrity of the public funds supporting the program.

The Department of Human Services is committed to this goal by providing staff and resources to the prevention, detection, and correction of abuse. However, this task can only be accomplished through the cooperation and support of the provider community. The clinical nurse specialist is often in a position to detect certain program abuses.

- B. A clinical nurse specialist who suspects either beneficiary or provider abuse, or unacceptable quality of care should contact the Utilization Review Section of Arkansas Division of Medical Services. An investigation will be conducted. [View or print the Arkansas Division of Medical Services Utilization Review Section contact information.](#)
- C. Examples of the types of abuse you may detect include:
1. Beneficiary over-utilization of services;
 2. Beneficiary misuse or inappropriate utilization of services;
 3. Beneficiary misuse of I.D. card;
 4. Poor quality of service; or
 5. Provider over-utilization or abuse.

204.000 Role of Quality Improvement Organization (QIO)

11-1-26

The **Quality Improvement Organization (QIO)** reviews all federally and state funded hospital inpatient services, as well as some outpatient and professional services delivered by Medicaid enrolled providers. The purpose of such review is the promotion of effective, efficient, and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to ensure that federal payment for services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards, and provided in the most appropriate and least costly setting and location.

A pattern of unusual practice may result in a clinical nurse specialist having prepayment review of up to one hundred percent (100%) of admissions. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction

11-1-26

The Arkansas Medicaid and CHIP Programs are designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in [Section I of this manual](#). All Medicaid and CHIP benefits are based upon medical necessity. [See the Glossary of this manual \(Section IV\) for the definition of “medical necessity”.](#)

212.000 Clinical Nurse Specialist

11-1-26

A clinical nurse specialist, as applicable to this program, is a licensed professional nurse who meets the participation requirements and enrollment criteria for advanced practice nursing defined by the state licensing authority.

The clinical nurse specialist provides direct care to individuals, families, and other groups in a variety of settings including homes, hospitals, nursing homes, offices, industries, schools, and other institutions and health care settings. The service provided by the clinical nurse specialist is directed toward the delivery of primary, secondary, and tertiary care that focuses on the achievement and maintenance of optimal functions in the population.

The clinical nurse specialist engages in independent decision-making about the health care needs of patients and collaborates with health professionals and others in making decisions about other health care needs. The clinical nurse specialist plans and initiates health care programs as a member of the health care team. The Clinical Nurse Specialist is directly accountable and responsible for the quality of care provided.

213.000 Scope 11-1-26

The scope of the Clinical Nurse Specialist Program includes Medicaid covered services provided by pediatric, family, obstetric-gynecologic (women's health care), and gerontological nurse practitioners in accordance with state and federal regulations.

214.000 Coverage 11-1-26

Many clinical nurse specialist services covered by the Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services that beneficiaries may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 and Section 252.484 for information about covered clinical nurse specialist services with restrictions, benefit limits, or both.

214.100 Exclusions 11-1-26

Exclusions are those services not covered in the Medicaid Clinical Nurse Specialist Program and any covered services furnished by a clinical nurse specialist that are not within their scope of practice as defined by the state licensing authority and by the national certifying body. Services are not covered when provided by an employed or contracted clinical nurse specialist who is not enrolled in the Clinical Nurse Specialist Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented for diagnoses that certify medical necessity.

214.200 General Clinical Nurse Specialist Services 11-1-26

- A. Services provided by a clinical nurse specialist include initial visits and established patient visits for:
 - 1. Diagnosis and evaluation
 - 2. Treatment services
 - 3. Health management services for prevention and early intervention
 - 4. Appropriate referrals to other health care providers for diagnostic and treatment services
- B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Clinical Nurse Specialist Services Benefit Limits 11-1-26

- A. For clients twenty-one (21) years of age or older, Clinical Nurse Specialist services provided in a physician office, an APRN office, a Clinical Nurse Specialist office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following other services are counted toward the Service Benefit Limits for Clinical Nurse Specialists:

- 1. APRN services in the office, patient's home, or nursing facility;
- 2. Physician services in the office, patient's home or nursing facility;
- 3. Rural health clinic (RHC) encounters;
- 4. Medical services furnished by a dentist;

5. Medical services furnished by an optometrist;
6. Certified nurse-midwife services in the office, patient's home or nursing facility;
7. Federally qualified health center (FQHC) encounters; and
8. Physician Assistant services.

The established benefit limit does not apply to clients under twenty-one (21) years of age.

Office visits are not counted toward the visit limit when one of the following is the primary diagnosis being treated: malignant Neoplasm, renal failure, HIV/AIDS, opioid use disorder when visits are part of a Medication Assisted Treatment (MAT) plan, and pregnancy.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.300 Reserved 11-1-26

214.310 Reserved 11-1-26

214.320 Reserved 11-1-26

214.321 Family Planning Services for Women in Aid Category 61, PW 11-1-26

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered services, including family planning services through the last day of the month in which the sixtieth (60th) day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 Family Planning Coverage Information 11-1-26

- A. Medicaid encourages reproductive health and family planning by reimbursing clinical nurse specialists for a comprehensive range of family planning services.
 1. Family planning services do not require a PCP referral.
 2. Medicaid beneficiaries' family planning service benefits are in addition to their other medical benefits when providers bill the services specifically as family planning services.
 3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
 4. Extension of benefits is not available for family planning services.
 5. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Other than full coverage aid categories, Arkansas Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this Manual for service description and coverage information.
- C. Clinical Nurse Specialists desiring to participate in the Medicaid Family Planning Services Program may do so by providing the services listed in Sections 214.321 through 214.333 to Medicaid beneficiaries of childbearing age.
- D. Clinical Nurse Specialists preferring not to provide family planning services may refer their patients to other providers. DHS County Offices maintain listings of local, and area providers qualified to provide family planning services. Listed providers include:
 1. Local Department of Health local health units;

2. Obstetricians and gynecologists;
 3. Physicians and Physician Assistants;
 4. Rural Health Clinics;
 5. Federally Qualified Health Centers;
 6. Family planning clinics;
 7. Nurse Practitioners; and
 8. Certified Nurse-Midwives.
- E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Clinical Nurse Specialist Basic Family Planning Visit**11-1-26**

Medicaid covers one (1) basic family planning visit per beneficiary per state fiscal year (July 1 through June 30). The basic family planning visit comprises the following:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight, and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam.
 2. The full range of contraceptive methods available.
 3. HIV and STI prevention.
- C. Prescription for any contraceptives selected by the beneficiary.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test.
 2. Hemoglobin and hematocrit.
 3. Sickle cell screening.
 4. Urinalysis testing for albumin and glucose.
 5. Papanicolaou (PAP) smears for cervical cancer.
 6. Testing for sexually transmitted infections.

214.332 Clinical Nurse Specialist Periodic Family Planning Visit**11-1-26**

Medicaid covers three (3) periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure, laboratory services as identified in Section 214.331 (D), and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription, and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception**11-1-26**

- A. Prescription and Non-Prescription Contraceptives:
 1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.

2. Medicaid covers non-prescription contraceptives as a family planning benefit when a qualified prescriber writes a prescription for them.
- B. Contraceptive Implant Systems:
1. Medicaid covers the contraceptive implant systems as a family planning benefit, including implants and supplies.
 2. Medicaid covers insertion, removal, and removal with reinsertion.
- C. Intrauterine Device (IUD):
1. Medicaid pays for IUDs as a family planning benefit.
 2. Medicaid reimburses providers who supply the IUD at the time of insertion.
 3. Medicaid pays providers for IUD insertion and removal.
- D. Medroxyprogesterone Acetate:
- Medicaid covers medroxyprogesterone acetate injections for birth control as a family planning benefit.
- E. Sterilization:
1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
 2. Medicaid covers Occlusion by Placement of Permanent Implants. Coverage includes the procedure, the implant device, and follow-up procedures as specified in Section 252.430.
 3. Refer to Sections 252.430 through 252.431 of this Manual for procedure codes and billing instructions for family planning services.

214.400 **Reserved** **11-1-26**

214.500 **Laboratory and X-Ray Services Referral Requirements** **11-1-26**

A clinical nurse specialist who refers a Medicaid beneficiary for laboratory, radiology, or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order*, pertinent supplemental diagnoses supporting the need for the test(s).

Clinical Nurse Specialists must meet the rules and regulations related to laboratory and X-Ray Services found in [Section II of the Medicaid Physician Provider Manual](#).

214.600 **Obstetrical Services** **11-1-26**

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW clients are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the 60th postpartum day falls.

Aid Category 62-PW-PE (Pregnant Women, Presumptively Eligible) receives prenatal services and services for conditions that may complicate the pregnancy. These services are limited to the outpatient setting only.

214.610 **Covered Clinical Nurse Specialist Obstetrical Services** **11-1-26**

Covered clinical nurse specialist obstetrical services may be provided when medically necessary and are *limited* to antepartum and postpartum care. Appropriate referrals will be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High-Risk Pregnancy**11-1-26**

A clinical nurse specialist may provide risk management services if he or she employs the professional staff indicated in service descriptions below. If a clinical nurse specialist does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment includes a medical, nutritional, and psychosocial assessment by a clinical nurse specialist or a registered nurse on the clinical nurse specialist's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form, includes:
 - a. Medical history;
 - b. Menstrual history; and
 - c. Pregnancy history.
2. Nutritional assessment includes:
 - a. 24-hour diet recall;
 - b. Screening for anemia; and
 - c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) assessment (units) per pregnancy

B. Case Management Services

Case management services are provided by a clinical nurse specialist, nurse practitioner, a licensed social worker, or registered nurse, to assist pregnant women eligible under Medicaid, in gaining access to needed medical, social, educational, and other services (examples include, but are not limited to, locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, and following up to verify that the patient kept her appointment, rescheduling the appointment).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. A case management contact may be with the patient, other professionals, family, or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, public health nurse, nutritionist, or health educator) include:

1. Pregnancy;
2. Labor and delivery;

3. Reproductive health;
4. Postpartum care;
5. Nutrition in pregnancy; and
6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors with development of a nutritional care plan; and
2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) consultations (units) per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors with development of a social work care plan
2. Social work plan follow-up, appropriate intervention and referrals

Maximum: Six (6) consultations (units) per pregnancy

E. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be done by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours if there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in Section 252.450.

214.700 **Reserved**

11-1-26

214.710 **Inpatient Services**

11-1-26

Clinical nurse specialist inpatient services must meet the Medicaid requirement of medical necessity. [The Quality Improvement Organization \(QIO\)](#) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary. Inpatient services are subject to QIO review for medical necessity whether the clinical nurse specialist's supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Clinical nurse specialist claims and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

All medical staff must provide inpatient services in compliance with Section 6 of the [Arkansas State Board of Health Rules for Hospitals and Related Institutions in Arkansas](#).

214.711 Medicaid Utilization Management Program (MUMP)

11-1-26

The Medicaid Utilization Management Program (MUMP) determines the covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Medicaid Program.

Clinical Nurse Specialists must meet the rules and regulations related to MUMP found in 224.200 – 224.400, [Section II of the Medicaid Physician Provider Manual](#).

214.712 Evaluation and Management

11-1-26

- A. Medicaid covers clinical nurse specialist evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses clinical nurse specialists for medically necessary discharge day management unless the clinical nurse specialist evaluation and management services for that day are included in another service, or unless the clinical nurse specialist does not customarily bill private-pay patients for discharge day management.
- B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the clinical nurse specialist sees the patient.
- C. The Medicaid Program will recover payments to clinical nurse specialists for inpatient evaluation and management services on days when the hospital's inpatient claims are denied (or would be denied, if filed) for:
 - 1. Exceeding benefit limits;
 - 2. Failure to pre-certify inpatient days, when applicable; or
 - 3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures

11-1-26

Hospital reimbursement for inpatient services covered by Medicaid includes the non-professional components (technical components), such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to clinical nurse specialists and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of the machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed for diagnosing and treating an inpatient hospital beneficiary. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits

11-1-26

An annual benefit limit of twenty-four (24) medically necessary days per state fiscal year (July 1 through June 30) applies for Medicaid beneficiaries twenty-one (21) years of age and older. Once the beneficiary exhausts the twenty-four (24) day annual limit, reimbursement for any additional inpatient hospital days will be reduced to four hundred dollars (\$400) per day and is subject to recoupment if later determined not medically necessary.

Inpatient hospital benefit limits do not apply for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 11-1-26

Outpatient hospital clinical nurse specialist services are divided into two (2) types of service for the purpose of coverage and reimbursement determination: Emergency Services and Non-Emergency Services.

Emergency and non-emergency services are described in Sections 213.200 through 213.612 of the [Medicaid Hospital Provider Manual](#)

214.800 Occupational Therapy, Physical Therapy, and Speech-Language Pathology 11-1-26

Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries by qualified occupational, physical, or speech-language therapy providers. Therapy services are not covered as clinical nurse specialist services. Please refer to the [Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Manual](#) for rules, guidelines, and referral information related to this program.

214.900 Procedures for Obtaining Extension of Benefits 11-1-26

Clinical nurse specialists who perform diagnostic laboratory services, radiology, or other services within their scope of practice may request extension of benefits for those services if the patient has exhausted the benefit limit.

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 11-1-26

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting. Please refer to Section 229.100 through 229.130 of the [Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual](#) for information about requesting extension of benefits.

214.940 Administrative Reconsideration and Appeals 11-1-26

- 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](#).

214.950 Reserved 11-1-26

214.952 Continued Services During the Appeal Process 11-1-26

Services may be continued pending the outcome of an appeal in accordance with Section 161.500 of this Manual.

215.000 Fluoride Varnish Treatment 11-1-26

Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at <http://ar.train.org>. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization 11-1-26

- A. Certain medical and surgical services are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.
- B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical services covered by the Arkansas Medicaid Program. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.](#)
 1. Prior authorization determinations are made in accordance with established medical or administrative criteria as determined in the professional judgment of physician advisors to Arkansas Medicaid.
 2. Payment for prior-authorized services is in accordance with federal regulations.
- C. Prior authorization of service does not guarantee payment of a service. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided; and that services are provided and billed in accordance with the prior authorization issued.

221.100 Post-Procedural Authorization for Beneficiaries Age 21 and Older 11-1-26

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age and older. Requests for post-procedural authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-procedural authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 11-1-26

- A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.
- B. The following process must be followed when obtaining a post-procedural authorization number.
 1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.](#)
 2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. [View or print contact information to obtain dates of eligibility.](#)

3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization

11-1-26

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program when prescribed by a clinical nurse specialist with prescriptive authority. Certain prescription drugs may require prior authorization. The prescriber is responsible for requesting and obtaining the prior authorization. Information may be obtained from DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor prescription drug information.](#)

The following information is available at the [DHS contracted Pharmacy Vendors website](#):

- A. Prescription drugs requiring prior authorization.
- B. Criteria for drugs requiring prior authorization.
- C. Forms to be completed for prior authorization.
- D. Procedures required of the prescriber to request and obtain prior authorization.

221.300 Procedures in the Outpatient Setting

11-1-26

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement

11-1-26

Medicaid reimbursement for clinical nurse specialist services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules

11-1-26

Arkansas Medicaid provides [fee schedules on the Arkansas Medicaid Division of Medical Services website](#). The fees represent the fee- for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage, or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid reimburses the lesser of the amount billed or the Medicaid maximum fee schedule amount.

232.000 Rate Review Process

11-1-26

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to [Section I](#), 110.400 of the manual to get instructions for requesting a review.

250.000 BILLING PROCEDURES**251.000 Introduction to Billing 11-1-26**

Clinical nurse specialist providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures 11-1-26**252.100 Reserved 11-1-26****252.110 Billing Protocol for Computed Tomographic Colonography (CT) 11-1-26**

- A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

- B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Clinical Nurse Specialist, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved 11-1-26**252.130 Special Billing Instructions 11-1-26**

- A. Use the following procedure codes for billing.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services](#)

- B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by the unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must also be met for payment to be approved.

252.131 Molecular Pathology 11-1-26

The following Molecular Pathology codes require prior authorization from DHS or its designated [QIO contractor](#). See Sections 221.000 through 221.300 for prior authorization procedures.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services](#)

252.132 Special Billing Requirements for Lab and X-Ray Services 11-1-26

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

- A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code.
- B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

All other billing requirements must also be met for payment to be approved.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services](#)

252.200 **Reserved**

11-1-26

252.210 **National Place of Service (POS) Codes**

11-1-26

Electronic and paper claims now require the same National Place of Service code. Clinical Nurse Specialists may provide services in the following locations:

Place of Service	POS Codes
Inpatient Hospital	21
Outpatient Hospital	22
Office	11
Patient's Home	12
Mobile Unit	15
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41
Other Locations	99
Telehealth	02
Telehealth in Home	10

252.300 **Billing Instructions – Paper Claims Only**

11-1-26

Bill Medicaid for clinical nurse specialist services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500](#).

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if required information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information](#).

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 **Completion of CMS-1500 Claim Form**

11-1-26

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message, contact, emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name and middle initial.
a.	OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b.	RESERVED	Reserved for NUCC use.
	SEX	Not required.
c.	RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not and will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. - On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month. - Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 292.200 for codes.
C. EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. * Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures 11-1-26

252.410 Clinic or Group Billing 11-1-26

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) clinical nurse specialist in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.420 Evaluations and Management 11-1-26

252.421 Initial Visit 11-1-26

The American Medical Association's *Current Procedures Terminology (CPT)* codes for a new patient should be used only for the first visit. Each subsequent visit should be billed using a CPT code denoting an established patient for office visits, home visits, nursing facility, visits, and emergency room visits. Refer to the latest edition of the CPT manual for detailed information.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service) 11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Procedure code must be used by clinical nurse specialists when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a clinical nurse specialist.

252.423 Inpatient Hospital Visits 11-1-26

Each clinical nurse specialist is limited to billing one (1) day of care for each inpatient hospital covered day, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management 11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits 11-1-26

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in a nursing facility.

252.426 Specimen Collections 11-1-26

The policy regarding collection, handling and conveyance of specimens is:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in the following circumstances : (1) drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or (2) collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.428 Services Not Considered a Separate Service from an Office Visit 11-1-26

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Specific procedure codes should never be used for billing routine pelvic examinations but should be used only when a pelvic examination is done under general anesthesia.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.429 Health Examinations for ARKids First B Beneficiaries and Medicaid Beneficiaries Under Age 21 11-1-26

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes 11-1-26

- A. Family planning services are covered for beneficiaries in full coverage aid categories or Aid Category 61 (PW). For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures.** Laboratory procedure codes covered for family planning are listed in Section 252.431.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, nurse practitioner, clinical nurse specialists, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, assistant surgeon, and other appropriate providers.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) may result in the delay or denial of payment for the sterilization procedures. The checklist on DMS-615 lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and claim for payment to be sure that all criteria have been met. [View or print form DMS-615 \(English\) and the checklist.](#) [View or print form DMS-615 \(Spanish\) and the checklist.](#)

C. The following procedure code table explains the family planning visit procedure codes and modifiers; laboratory procedure codes and modifiers; and pathology procedure codes and modifiers payable to clinical nurse specialists.

NOTE: The procedure codes with the modifiers denote the Arkansas Medicaid description.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

The FP modifier is used on the claim to indicate the procedure code is for family planning services.

If a procedure code is marked with a single asterisk, (*), bill using modifiers FP, SA.

If a venous blood specimen is marked with a double asterisk, (**), reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. Modifier FP for family planning services must be entered on the claim.

Family planning laboratory codes are found in Section 252.431.

252.431 Family Planning Laboratory Procedure Codes**11-1-26**

Family planning services are covered for beneficiaries in full coverage aid categories and Aid Category 61 (PW) For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The following procedure code table contains family planning laboratory procedure codes.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year.

**Payable only to pathologists and independent labs.

***Requires FP modifier only.

⌘See points B and C below for information regarding this procedure code.

- B. Laboratory codes payable to non-hospital-based clinical nurse specialists.

The following procedure code table contains laboratory services payable to non-hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

- C. Laboratory codes payable to hospital-based clinical nurse specialists.

The following procedure code table describes the laboratory services payable to hospital-based clinical nurse specialists.

NOTE: The procedure codes with the modifiers indicated below denote the Arkansas Medicaid description.

252.438 National Drug Codes (NDCs) 11-1-26

The Federal Deficit Reduction Act of 2005 mandates the submission of National Drug Codes (NDCs) on claims submitted with Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT) codes for drugs administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

Clinical Nurse Specialists must meet the rules and regulations related to NDCs found in 292.910 of [Section II of the Medicaid Physician Provider Manual](#).

252.440 Reserved 11-1-26

252.441 Family/Group Psychotherapy 11-1-26

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

Procedure codes are payable when the place of service is the beneficiary's home, the physician's office, a hospital or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes 11-1-26

The technical component radiology procedure codes listed on the Clinical Nurse Specialist fee schedule are payable when performed in the office place of service (11) if the clinical nurse specialist provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Clinical Nurse Specialist fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Clinical nurse specialist providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections 11-1-26

Clinical nurse specialists billing the Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the

specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code (“Z code”) are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can only be billed on a paper claim. When only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine 11-1-26

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer’s invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administrations fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved 11-1-26

252.446 Reserved 11-1-26

252.447 Reserved 11-1-26

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment 11-1-26
Drugs

Effective for dates of service on and after September 1, 2020, Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries . All rules and regulations promulgated within the Physician’s provider manual for provision of this service must be followed.

Effective for dates of services on and after October 1, 2018, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the [DHS contracted Pharmacy vendor website](#).

252.449 Influenza Virus Vaccine

11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

- A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

- B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for three (3) years of age and older.
1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. For individuals nineteen (19) years of age and older, no modifier is necessary.
- C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals who are five through forty-nine (5-49) years of age and who are not pregnant.
1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.
- D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.
- For ARKids First-B beneficiaries, use modifier **TJ**.
- E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.
1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy

11-1-26

Covered clinical nurse specialist obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A clinical nurse specialist may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the clinical nurse specialist employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered as one (1) service and are limited to thirty-two (32) cumulative units.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.452 Newborn Care

11-1-26

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn are responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) are responsible for the charges incurred by the newborn.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, clinical nurse specialist.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500 form; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. [View or print Provider Assistance Center contact information.](#)

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment

11-1-26

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

The American Dental Association (ADA) procedure code is covered by the Medicaid Program. This code is payable for beneficiaries under twenty-one (21) years of age. Topical fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification, will be tied to provider types 01, 03, 58, and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code can be added to their file in the MMIS. [View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.](#) After the FC-Fluoride Certification specialty code is added to the provider's file, the provider will be able to bill the procedure code for Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is

needed due to severe periodontal disease, the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). [View a CMS-1500 sample form.](#)

252.454 Tobacco Cessation Products and Counseling Services

11-1-26

- A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products, either prescribed or initiated through statewide pharmacist protocol, are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the DHS Contracted Pharmacy Vendor website or in the Prescription Drug Program Prior Authorization Criteria.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

*Exempt from PCP referral requirements.

***** (...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

- B. Two (2) Counseling visits per state fiscal year.
- C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.
- D. Can be billed in addition to an office visit or EPSDT.
- E. Sessions do not require a PCP referral.
- F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, they can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section C above.

The provider must complete the counseling checklist and place in the patient records for audit.

[View or print a copy of the checklist: Be Well Arkansas Referral Form.](#)

252.455 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services

11-1-26

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are payable to the clinical nurse specialist. Physical therapy may be payable to the physician when directly provided according to the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. See **[Glossary - Section IV](#)** - for definitions of "group" and "individual" as they relate to therapy services.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for beneficiaries of all ages for medically necessary physical and speech therapy.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 11-1-26

The following CPT procedure codes are covered for Medicaid beneficiaries.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.457 Procedures That Require Prior Authorization 11-1-26

- A. The following procedure code requires prior authorization by DHS or its designated contractor. (See Section 220.000 of this manual for prior authorization instructions.)
- B. The following Molecular Pathology codes require prior authorization from DHS or its designated contractor.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.458 Substitute Clinical Nurse Specialist 11-1-26

To comply with Section 4708 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the Arkansas Medicaid Program implemented the following requirements to adhere to **locum tenens clinical nurse specialist** and **substitute clinical nurse specialist** billing and coverage policies and procedures.

A. Description of Service

Locum tenens and substitute clinical nurse specialist are terms used to describe the relationship of a clinical nurse specialist who is acting as a fill-in for a beneficiary's regular clinical nurse specialist. The regular clinical nurse specialist could be a specialist the beneficiary sees regularly for a chronic condition or a specific problem. A locum tenens or substitute clinical nurse specialist must be the same discipline as the clinical nurse specialist. Documentation of the locum tenens arrangement must include the services provided, the date the services were performed, and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

B. Substitute Clinical Nurse Specialist

A substitute clinical nurse specialist is a clinical nurse specialist who is asked by the regular clinical nurse specialist to see a beneficiary in a reciprocal arrangement when the regular clinical nurse specialist is unavailable to see the beneficiary. In the substitute clinical nurse specialist arrangement, the regular clinical nurse specialist reciprocates the substitute clinical nurse specialist by paying the substitute the amount received for the service rendered or by serving in the same capacity in return. For this provision to occur, both the regular and the substitute clinical nurse specialist must be enrolled in Arkansas Medicaid.

The following billing protocol must be utilized for substitute clinical nurse specialist circumstances:

1. The regular clinical nurse specialist office submits the claim and receives payment using the regular Arkansas Medicaid provider number. The payment amount will be the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
2. The modifier Q5 must be placed in form indicator 24D of the CMS-1500 claim form to indicate services were rendered by a substitute clinical nurse specialist.

3. The substitute clinical nurse specialist arrangement should not exceed fourteen (14) consecutive days. The substitute clinical nurse specialist arrangement does not apply to substitution for clinical nurse specialists in the same medical group with claims submitted in the name of the medical group. (For situations in which a group member substitutes for another, the substitution is noted by listing the substitute group member number as the rendering provider in field 24J on the CMS-1500 claim form, and the Q5 modifier is **not** used. The **group number** is listed as the billing provider.)

C. Locum Tenens Clinical Nurse Specialists

A locum tenens arrangement is made when the regular clinical nurse specialist must leave his/her practice due to illness, vacation, or medical education opportunity and does not want to leave patients without service during this period. The locum tenens clinical nurse specialist usually has no practice of his or her own and moves from area to area as needed. The clinical nurse specialist is usually paid a fixed amount per diem with the status of an independent contractor, not an employee. The locum tenens clinical nurse specialist must meet all state, hospital, and other institutional credentialing requirements. The locum tenens clinical nurse specialist is required to be enrolled in Arkansas Medicaid.

Documentation of the locum tenens arrangement must include the services provided by the locum tenens and when those services were performed and must be made available upon request. A record of the service would include the date and place of the service, the procedure code, the charge, and the beneficiary involved.

The following billing protocol must be utilized for locum tenens clinical nurse specialist circumstances:

1. The regular clinical nurse specialist's office submits their claims for locum tenens services using the regular nurse practitioner's provider identification number.
2. Modifier Q6 is placed in the indicator 24D of the CMS-1500 claim form to indicate services were provided by a locum tenens clinical nurse specialist. The payment amount is the lesser of the billed amount or the Arkansas Medicaid allowed amount for the service provided.
3. Locum tenens arrangements should not exceed sixty (60) days. If a clinical nurse specialist is away more than sixty (60) days, additional locum tenens can be used to fill in for different sixty (60) day periods. This means that various clinical nurse specialists would be required to fill in for different sixty (60) day time periods. Locum tenens is not designed to fill clinical nurse specialist vacancies within the practice.

Exception: In accordance with Public Law 110-173, the exception to the sixty (60) day limit on substitute clinical nurse specialist billing occurs when a clinical nurse specialist is ordered to active military duty in the Armed Forces.

See the table below which compares the requirements for substitute and locum tenens clinical nurse specialists according to Arkansas Medicaid Policy.

REQUIREMENT	SUBSTITUTE Clinical Nurse Specialist	LOCUM TENENS Clinical Nurse Specialist
Must be enrolled as an Arkansas Medicaid Provider	Yes	Yes
May be enrolled by the same group as the regular clinical nurse specialist	No	No
Claims are submitted by the regular clinical nurse specialist's office and that office receives payment	Yes	Yes
Modifier required to identify arrangement	Yes, Q5	Yes, Q6
May use the regular clinical nurse specialist's certification code for PCP authorization	Yes	Yes
Maximum time frame allowed	14 days	60 days

252.460 Outpatient Hospital Services 11-1-26

252.461 Emergency Services 11-1-26

The appropriate CPT procedure codes should be used when billing for clinical nurse specialist visits in an outpatient hospital setting for emergency services.

252.462 Non-Emergency Services 11-1-26

Procedure code should be billed for a non-emergency clinical nurse specialist visit.

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

252.463 Outpatient Hospital Surgical Procedures 11-1-26

For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by the unlisted code. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

All other billing requirements must be met for payment to be approved.

252.464 Multiple Surgery 11-1-26

If multiple surgical procedures are done on the same date of service, but not in the same operative session, each should be coded in the "Procedures, Services or Supplies" field as a separate procedure.

252.465 Observation Status 11-1-26

When claims are filed for services provided to a patient in "observation status," clinical nurse specialists must adhere to Medicaid definitions of inpatient and outpatient.

Observation status is an outpatient designation. Clinical Nurse Specialists must also follow the guidelines and definitions in Current Procedural Terminology (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

- A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the clinical nurse specialist should consider the patient an outpatient (meaning the patient is an outpatient unless the clinical nurse specialist's supervising physician has admitted them as an inpatient).
- B. If the clinical nurse specialist or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the clinical nurse specialist's supervising physician has not yet formally admitted the patient.
- C. Medicaid also deems a patient admitted to inpatient status at the time they have remained in the hospital for twenty-four (24) consecutive hours, even if the clinical nurse specialist's supervising physician or hospital had no prior expectation of a stay of that or greater duration.

252.466 Billing Examples

11-1-26

The following table gives examples of appropriate clinical nurse specialist claims for several common hospital scenarios. In the table, instructions under the headings "CLINICAL NURSE SPECIALIST MAY BILL..." do not necessarily include all services that the clinical nurse specialist may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

ARKANSAS MEDICAID OBSERVATION STATUS POLICY ILLUSTRATION			
PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	CLINICAL NURSE SPECIALIST MAY BILL FOR TUESDAY SERVICES:	CLINICAL NURSE SPECIALIST MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care Discharge Day Management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and Management Services
Tuesday, 3:00 PM, after exam in Emergency Department—emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; Patient was Discharged Tuesday

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare**11-1-26**

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement**11-1-26**

Services that have been denied by Medicare with the explanation “Services Prior to Medicare Entitlement” may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the Inquiry Unit. [View or print the Inquiry Unit contact information.](#)

These services can usually be filed electronically unless they are covered by Medicare and the beneficiary was sixty-five (65) or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims so they may receive special handling.

252.482 Services Not Medicare Approved**11-1-26**

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare but are covered by Medicaid. These are exceptions and may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS**11-1-26**

- A. Effective for dates of service on and after 6/1/2022 drug treatment will be available to all qualifying Arkansas Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:
 1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
 2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).
- B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).
- C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:
 1. The drug treatment must be authorized under a Treatment Plan; and
 2. The Treatment Plan must be established by the approved PANS/PANDAS provider.
- D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. [View or print contact information for the QIO.](#)
- E. The authorized procedure codes and required modifiers are found in the following link:

[View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services, including PANS and PANDAS procedure codes.](#)

252.484 Injections, Therapeutic, and Diagnostic Agents**11-1-26**

Clinical nurse specialists shall administer injections, therapeutic, and diagnostic agents according to the rules set forth in the Medicaid Physician's policy manual and within the scope of their practice guidelines. [View or print the procedure codes for Clinical Nurse Specialist and Nurse Practitioner services.](#)

PROPOSED

TOC not required

210.200 Staff Requirements

117-1-264

Each Counseling and Crisis Services provider must ensure that they employ staff which are able and available to provide appropriate and adequate services offered by the provider. Counseling and Crisis Services staff members must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification, and supervision that are required for each performing provider type. Non-independently licensed clinicians must serve as a rendering provider through a certified agency provider.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Independently Licensed Clinicians – Master's/Doctoral	Licensed Certified Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be licensed through the relevant licensing board to provide services	Not Required
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) Provisionally Licensed Master Social Worker (PLMSW)	Yes, must be licensed through the relevant licensing board to provide services and be employed or contracted by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Licensed Alcoholism and Drug Abuse Counselor Master's	Licensed Alcoholism and Drug Abuse Counselor (LADAC) Master's Doctoral	Yes, must be licensed through the relevant licensing board to provide services	
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Not Required
<u>Physician Assistant</u>	<u>Physician Assistant license issued by the Arkansas State Medical Board.</u>	<u>Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency</u>	<u>Physician Supervision and Delegation Agreement Required</u>

The services of a medical records librarian are required. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care, and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved; that required indexes and registries are maintained, and that statistical reports are prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable, establishing a central records index, and maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

When a Counseling and Crisis Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

TOC not required

210.200 Staff Requirements

11-1-26

Each Counseling and Crisis Services provider must ensure that they employ staff which are able and available to provide appropriate and adequate services offered by the provider. Counseling and Crisis Services staff members must provide services only within the scope of their individual licensure. The following chart lists the terminology used in this provider manual and explains the licensure, certification, and supervision that are required for each performing provider type. Non-independently licensed clinicians must serve as a rendering provider through a certified agency provider.

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Independently Licensed Clinicians – Master's/Doctoral	Licensed Certified Social Worker (LCSW) Licensed Marital and Family Therapist (LMFT) Licensed Psychologist (LP) Licensed Psychological Examiner – Independent (LPEI) Licensed Professional Counselor (LPC)	Yes, must be licensed through the relevant licensing board to provide services	Not Required
Non-independently Licensed Clinicians – Master's/Doctoral	Licensed Master Social Worker (LMSW) Licensed Associate Marital and Family Therapist (LAMFT) Licensed Associate Counselor (LAC) Licensed Psychological Examiner (LPE) Provisionally Licensed Psychologist (PLP) Provisionally Licensed Master Social Worker (PLMSW)	Yes, must be licensed through the relevant licensing board to provide services and be employed or contracted by a certified Behavioral Health Agency, Community Support System Agency, or certified by the Dept. of Education as a school-based mental health provider	Required

PROVIDER TYPE	LICENSES	STATE CERTIFICATION REQUIRED	SUPERVISION
Licensed Alcoholism and Drug Abuse Counselor Master's	Licensed Alcoholism and Drug Abuse Counselor (LADAC) Master's Doctoral	Yes, must be licensed through the relevant licensing board to provide services	
Advanced Practice Nurse (APN)	Adult Psychiatric Mental Health Clinical Nurse Specialist Child Psychiatric Mental Health Clinical Nurse Specialist Adult Psychiatric Mental Health APN Family Psychiatric Mental Health APN	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Collaborative Agreement with Physician Required
Physician	Doctor of Medicine (MD) Doctor of Osteopathic Medicine (DO)	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Not Required
Physician Assistant	Physician Assistant license issued by the Arkansas State Medical Board.	Must be employed or contracted by a certified Behavioral Health Agency, or Community Support System Agency	Physician Supervision and Delegation Agreement Required

The services of a medical records librarian are required. The medical records librarian (or person performing the duties of the medical records librarian) shall be responsible for ongoing quality controls, for continuity of patient care, and patient traffic flow. The librarian shall assure that records are maintained, completed and preserved; that required indexes and registries are maintained, and that statistical reports are prepared. This staff member will be personally responsible for ensuring that information on enrolled patients is immediately retrievable, establishing a central records index, and maintaining service records in such a manner as to enable a constant monitoring of continuity of care.

When a Counseling and Crisis Services provider files a claim with Arkansas Medicaid, the staff member who actually performed the service must be identified on the claim as the rendering provider. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300, and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

TOC required

212.200 FQHC Core Services**4-1-2211-1-
26**

Covered FQHC core services are:

- A. Physician services;
- B. Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered);
- C. Pneumococcal vaccine and its administration and influenza vaccine and its administration;
- D. Services provided by physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical psychologists, clinical social workers, licensed certified social workers, licensed professional counselors, licensed mental health counselors, and licensed marriage and family therapists;
- E. Services and supplies incidental to physician assistant, nurse practitioner, clinical nurse specialists, certified nurse-midwives, clinical psychologist, clinical social worker, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incidental to physician services; and
- F. ~~Part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary of the Department of Health and Human Services has determined there is a shortage of home health agencies~~ Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440-70.

212.220 Services Furnished in Collaboration with a Physician**2-1-2411-1-
26**

Nurse practitioner, certified nurse-midwife, and clinical nurse specialist services ~~are may be~~ performed in collaboration with a physician or physicians. Physician Assistant services are performed under the supervision of and in collaboration with the physician.

- A. Collaboration is a process in which a nurse practitioner, certified nurse-midwife, physician assistant, or clinical nurse specialist works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.
- B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.
- C. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

212.230 Services and Supplies ~~""Incident To""~~ a Nurse Practitioner's or Physician Assistant's Services**10-13-0311-
1-26**

- A. Services and supplies ~~""incident to""~~ a nurse practitioner's, clinical nurse specialist, or physician assistant's services are covered if the service or supply is:

1. Of a type commonly furnished in physicians' offices;
 2. Of a type commonly furnished either without charge or included in the FQHC's bill;
 3. Furnished as an incidental, although integral, part of the professional services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant;
 4. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic and
 5. Furnished under the direct supervision of a nurse practitioner, physician assistant, clinical nurse specialist, or a physician as follows:
 - a. The nurse practitioner, clinical nurse specialist, physician assistant, or physician must be physically present (under the same roof and immediately available for consultation) when the services are furnished and
 - b. A nurse practitioner, clinical nurse specialist, or physician assistant may fill this supervisory function only if such a person is permitted to supervise such services under state law and the written policies governing the FQHC.
- B. Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

214.100 Definition of an FQHC "Core Service" Encounter

4-1-2211-1-26

A Federally Qualified Health Center (FQHC) "core service" encounter is a face-to-face contact between a patient of the FQHC and a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist and includes services and supplies incidental to the face-to-face contact.

220.000 Benefit Limits

117-1-265

- A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; ~~and~~
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility;
8. Physician assistant services; and
9. Clinical nurse specialist services in the office, patient's home, or nursing facility.

- B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:
1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.

2. Services for the following diagnoses: malignant neoplasm, renal failure, HIV/AIDS, pregnancy, or opioid use disorder when the service is part of a Medication Assisted Treatment Plan.
- C. For beneficiaries age twenty-one (21) and over, extension of benefits can be obtained to exceed the sixteen-visit limit. To request an extension of benefit, please contact the Medicaid designated QIO.
- ~~2.~~ ~~Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.~~
- ~~3.~~ ~~Postpartum visits are to be billed as an encounter, with an appropriate postpartum diagnosis code. These will not count against the FQHC encounter benefit limit.~~
- ~~4.~~ ~~Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.~~
- ~~5.~~ ~~Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis ([View ICD OUD Codes](#)).~~
- DG. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

TOC required**212.200 FQHC Core Services****11-1-26**

Covered FQHC core services are:

- A. Physician services;
- B. Services and supplies incidental to physician services (including drugs and biologicals that cannot be self-administered);
- C. Pneumococcal vaccine and its administration and influenza vaccine and its administration;
- D. Services provided by physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical psychologists, clinical social workers, licensed certified social workers, licensed professional counselors, licensed mental health counselors, and licensed marriage and family therapists;
- E. Services and supplies incidental to physician assistant, nurse practitioner, clinical nurse specialists, certified nurse-midwives, clinical psychologist, clinical social worker, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incidental to physician services; and
- F. Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440-70.

212.220 Services Furnished in Collaboration with a Physician**11-1-26**

Nurse practitioner, certified nurse-midwife, and clinical nurse specialist services may be performed in collaboration with a physician or physicians. Physician Assistant services are performed under the supervision of and in collaboration with the physician.

- A. Collaboration is a process in which a nurse practitioner, certified nurse-midwife, physician assistant, or clinical nurse specialist works with one (1) or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction, and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by State law.
- B. The collaborating physician does not need to be present with the nurse practitioner when the services are furnished or to make an independent evaluation of each patient who is seen by the nurse practitioner.
- C. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to all qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

212.230 Services and Supplies "Incident To" a Nurse Practitioner's or Physician Assistant's Services**11-1-26**

- A. Services and supplies "incident to" nurse practitioner, clinical nurse specialist, or physician assistant services are covered if the service or supply is:
 - 1. Of a type commonly furnished in physicians' offices;
 - 2. Of a type commonly furnished either without charge or included in the FQHC's bill;
 - 3. Furnished as an incidental, although integral, part of the professional services furnished by a nurse practitioner, clinical nurse specialist, or physician assistant;

4. In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic and
 5. Furnished under the direct supervision of a nurse practitioner, physician assistant, clinical nurse specialist, or a physician as follows:
 - a. The nurse practitioner, clinical nurse specialist, physician assistant, or physician must be physically present (under the same roof and immediately available for consultation) when the services are furnished and
 - b. A nurse practitioner, clinical nurse specialist, or physician assistant may fill this supervisory function only if such a person is permitted to supervise such services under state law and the written policies governing the FQHC.
- B. Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

214.100 Definition of an FQHC "Core Service" Encounter**11-1-26**

A Federally Qualified Health Center (FQHC) "core service" encounter is a face-to-face contact between a patient of the FQHC and a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed mental health counselor, or licensed marriage and family therapist and includes services and supplies incidental to the face-to-face contact.

220.000 Benefit Limits**11-1-26**

- A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).
- The following services are counted toward the sixteen (16) encounters per SFY benefit limit:
1. Federally Qualified Health Center (FQHC) encounters;
 2. Physician visits in the office, patient's home, or nursing facility;
 3. Certified nurse midwife visits;
 4. RHC encounters;
 5. Medical services provided by a dentist;
 6. Medical services provided by an optometrist;
 7. Advanced practice registered nurse services in the office, patient's home, or nursing facility;
 8. Physician assistant services; and
 9. Clinical nurse specialist services in the office, patient's home, or nursing facility.
- B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:
1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
 2. Services for the following diagnoses: malignant neoplasm, renal failure, HIV/AIDS, pregnancy, or opioid use disorder when the service is part of a Medication Assisted Treatment Plan.
- C. For beneficiaries age twenty-one (21) and over, extension of benefits can be obtained to exceed the sixteen-visit limit. To request an extension of benefit, please contact the Medicaid designated QIO.

- D. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

PROPOSED

TOC required

206.000 Documentation of Services

711-1-1726

Home Health providers must maintain ~~the following~~ records for patients of all ages; see Section 218.000 for additional documentation guidelines regarding physical therapy for patients under the age of twenty-one (21). Additional information regarding documentation of services is ~~located~~ in Section 140.000 of this manual. Required records for all ages include:

- A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable~~;~~
- B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants~~,~~ and physical therapists~~;~~
- C. Signed and dated documentation of pro re nata (PRN) visits, which must include the following:
 1. The medical justification for each such unscheduled visit~~;~~
 2. The patient's vital signs and symptoms~~;~~
 3. The observations of and measures taken by agency staff and reported to the physician~~;~~
 4. The physician's comments, observations~~,~~ and instructions.
- D. ~~Documented v~~Verification~~, by means of physician or approved non-physician practitioner documentation, that there was of~~ a face-to-face encounter with the beneficiary that meets the following requirements:
 1. ~~For the initiation of home health services, t~~The face-to-face encounter initiating the home health services must be related to the primary reason the beneficiary requires home health services and must occur within the ninety (90) days before or within thirty (30) days after the start of services.
 2. ~~For the initiation of medical equipment, t~~The face-to-face encounter initiating medical equipment must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
 3. The face-to-face encounter may be conducted by one of the following practitioners:
 - a. The primary care ~~physician.provider;~~
 - b. A nurse practitioner working in collaboration with the primary care ~~physician.provider when the nurse practitioner is not the PCP of the beneficiary;~~
 - c. A certified nurse midwife ~~by pursuant to his or her the~~ scope of practice~~;~~
 - d. A physician assistant ~~under the supervision of the primary care physician according to Arkansas Medicaid physician policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician for which the physician takes full responsibility. The service is not considered to be separate from the physician's service.working in collaboration with the primary care provider when the physician assistant is not the PCP of the beneficiary;~~
 - e. ~~For beneficiaries admitted to home health immediately after an acute or post-acute stay, t~~The attending acute or post-acute physician~~, when beneficiaries are admitted to home health immediately after an acute or post-acute stay; or~~

- f. A clinical nurse specialist working in collaboration with the primary care provider when the clinical nurse specialist is not the PCP of the beneficiary.
4. The allowed non-physician practitioner performing ~~the~~ face-to-face encounter must communicate the clinical findings of ~~the~~ face-to-face encounter to the ordering physician or PCP. ~~These~~ clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the physician-provider ordering the services must:
 - a. Document the face-to-face encounter, ~~which is related to the primary reason the patient requires home health services,~~ occurred within the required timeframes prior to the start of home health services. The face-to-face encounter must verify the primary reason the beneficiary requires home health services.
 - b. Must Document indicate the practitioner who conducted the encounter and the date and time of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter and appropriate for that beneficiary.
- E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would qualify as a durable medical equipment (DME) claim under the Medicare program unless the primary care physicianPCP or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in (D) 3 of this section ~~with the exception of for the nurse midwives.~~
- F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications, in each patientbeneficiary's medical records.
- G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.
- H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.
- I. The registered nurse's ~~(or physical therapist's when applicable)~~ notes from supervisory visits or the physical therapist's notes from supervisory visits, when applicable.

232.000

Rate AppealReview Process10-13-0311-
1-26

A provider may request reconsideration review of a ~~P~~program decision rate policy or procedure by writing to the ~~Assistant~~ Director, Division of Medical Services (DMS). Refer to Section I, 110.400 of the manual to get instructions for requesting a review. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of

Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

MARK-UP

TOC required**206.000 Documentation of Services****11-1-26**

Home Health providers must maintain records for patients of all ages; see Section 218.000 for additional documentation guidelines regarding physical therapy for patients under the age of twenty-one (21). Additional information regarding documentation of services is in Section 140.000 of this manual. Required records for all ages include:

- A. Signed and dated patient assessments and plans of care, including physical therapy evaluations and treatment plans when applicable;
- B. Signed and dated case notes and progress notes from each visit by nurses, aides, physical therapy assistants, and physical therapists;
- C. Signed and dated documentation of pro re nata (PRN) visits, which must include the following:
 - 1. The medical justification for each such unscheduled visit;
 - 2. The patient's vital signs and symptoms;
 - 3. The observations of and measures taken by agency staff and reported to the physician;
 - 4. The physician's comments, observations, and instructions.
- D. Documented verification of a face-to-face encounter with the beneficiary that meets the following requirements:
 - 1. The face-to-face encounter initiating the home health services must be related to the primary reason the beneficiary requires home health services and must occur within the ninety (90) days before or within thirty (30) days after the start of services.
 - 2. The face-to-face encounter initiating medical equipment must be related to the primary reason the beneficiary requires medical equipment and must occur no more than six (6) months prior to the start of services.
 - 3. The face-to-face encounter may be conducted by one of the following practitioners:
 - a. The primary care provider;
 - b. A nurse practitioner working in collaboration with the primary care provider when the nurse practitioner is not the PCP of the beneficiary;
 - c. A certified nurse midwife pursuant to his or her scope of practice;
 - d. A physician assistant working in collaboration with the primary care provider when the physician assistant is not the PCP of the beneficiary;
 - e. The attending acute or post-acute physician when beneficiaries are admitted to home health immediately after an acute or post-acute stay; or
 - f. A clinical nurse specialist working in collaboration with the primary care provider when the clinical nurse specialist is not the PCP of the beneficiary.
 - 4. The allowed non-physician practitioner performing a face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician or PCP. The clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record.
 - 5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the provider ordering the services must:
 - a. Document the face-to-face encounter occurred within the required timeframes prior to the start of home health services. The face-to-face encounter must

- verify the primary reason the beneficiary requires home health services.
- b. Document the practitioner who conducted the encounter and the date and time of the encounter.
6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter and appropriate for that beneficiary.
- E. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would qualify as a durable medical equipment (DME) claim under the Medicare program unless the PCP or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in (D) 3 of this section except for nurse midwives.
 - F. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications, in each beneficiary's medical records.
 - G. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention.
 - H. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit.
 - I. The registered nurse's notes from supervisory visits or the physical therapist's notes from supervisory visits, when applicable.

232.000 Rate Review Process**11-1-26**

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to [Section I, 110.400 of the manual](#) to get instructions for requesting a review.

*TOC not required***202.000 Hospital and CAH Medical Record Requirements****118-1-0526**

- A. Hospitals and CAHs must maintain a medical record for each inpatient and outpatient beneficiary.
 - 1. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible.
 - 2. The facility's system of author identification and record maintenance must ensure the integrity of the authentication and protect the security of all recorded entries.
- B. The medical record must:
 - 1. Justify admission and continued hospitalization,
 - 2. Support the diagnosis and
 - 3. Describe the patient's progress and response to medications and services.
- C. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.
 - 1. The author of each entry must be identified and must authenticate his or her entry.
 - 2. Authentication may include signatures, written initials, or computer entry.
- D. All records must document the following, as appropriate:
 - 1. Required primary care physician-provider (PCP), ~~or~~ other referrals, or both, when applicable;
 - 2. A physical examination, including a health history, performed no more than seven (7) days before admission or within forty-eight (48) hours after admission;
 - 3. Admitting diagnosis;
 - 4. Results of all consultative evaluations of the patient beneficiary and appropriate findings by clinical and other staff involved in the care of the patient beneficiary;
 - 5. Documentation of complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia;
 - 6. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or specified by federal or state law when applicable, ~~to which~~ require written patient consent;
 - 7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs, and other information necessary to monitor the patient beneficiary's condition;
 - 8. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;
 - 9. Final diagnosis with completion of medical records within thirty (30) days following discharge.

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures**7-1-2211-1-26**

- A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.

1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).
2. Diagnostic laboratory services benefits are limited to five hundred dollars (\$500) per SFY, and radiology/other services benefits are limited to five hundred dollars (\$500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. 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. The benefit limits apply to ~~claims~~ payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, ~~C~~ertified ~~N~~nurse-~~M~~midwives (CNMs), ~~N~~nurse ~~P~~practitioners (NP), ~~physician assistants, clinical nurse specialists, and A~~mbulatory ~~S~~surgical ~~C~~centers (ASCs).
- C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.
- D. Extension of these ~~se~~ benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:
 1. Malignant neoplasm ([View ICD Codes](#));
 2. HIV infection and AIDS ([View ICD Codes](#));
 3. Renal failure ([View ICD Codes](#));
 4. Pregnancy* ([View ICD Codes](#)): or
 5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). ([View ICD OUD Codes](#)) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD ([View Laboratory and Screening Codes](#)).
- E. ~~*Obstetric (OB) ultrasounds and fetal non stress tests have benefit limits that are not exempt from Extension of Benefits request requirements. (See Section 215.041 for additional coverage information.)~~
- F. ~~—~~ Magnetic Resonance Imaging (MRI) is exempt from the ~~five-hundred-dollar~~ radiology/other services ~~state fiscal year (SFY)~~ benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)
- GF. Cardiac catheterization procedures are exempt from the ~~five-hundred-dollar~~~~SFY~~ outpatient diagnostic laboratory services benefit limit and the ~~five-hundred-dollar~~~~SFY~~ radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiary's ~~'sies'~~ medical record.
- HG. ~~There are no b~~Benefit limits ~~generally do not apply~~ on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program, ~~except for the limitations on fetal echography (ultrasound) and fetal non stress tests.~~

~~*OB ultrasounds and fetal non stress tests are not exempt from Extension of Benefits. See Section 215.041 for additional coverage information.~~

216.130 Family Planning Coverage Information**~~1-15-1511-~~
1-26**

- A. ~~Arkansas~~ Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse midwives, physician assistants, clinical nurse specialists, clinics, and hospitals for a comprehensive range of family planning services.
1. Family planning services do not require a PCP referral.
 2. ~~Medicaid beneficiaries'~~ Family planning services benefits are in addition to their Medicaid beneficiary's other medical benefits, when providers bill the services specifically as family planning services.
 3. Abortion is not a family planning service in the Arkansas Medicaid Program.
- B. Hospitals ~~desiring to~~ participate in the ~~Medicaid~~ Family Planning Services Program ~~may do so~~ by providing the services listed in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 to Medicaid beneficiaries of childbearing age.
- C. Hospitals preferring not to provide family planning services may share ~~with their patients~~ other sources for these services with their patients. ~~DHS County Offices maintain listings of local and area providers qualified to provide family planning services.~~ Listed providers include:
1. ~~Arkansas Local~~ Department of Health ~~local health~~ units
 2. Obstetricians and gynecologists
 3. Nurse practitioners
 4. Certified nurse-midwives
 54. Rural Health Clinics
 65. Federally Qualified Health Centers
 76. Family planning clinics
 8. Physician Assistants
 9. Clinical Nurse Specialists
- D. Complete billing instructions for family planning services are contained in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 of this manual.

*TOC not required***202.000 Hospital and CAH Medical Record Requirements 11-1-26**

- A. Hospitals and CAHs must maintain a medical record for each inpatient and outpatient beneficiary.
 - 1. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible.
 - 2. The facility's system of author identification and record maintenance must ensure the integrity of the authentication and protect the security of all recorded entries.
- B. The medical record must:
 - 1. Justify admission and continued hospitalization,
 - 2. Support the diagnosis and
 - 3. Describe the patient's progress and response to medications and services.
- C. All entries must be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.
 - 1. The author of each entry must be identified and must authenticate his or her entry.
 - 2. Authentication may include signatures, written initials, or computer entry.
- D. All records must document the following, as appropriate:
 - 1. Required primary care provider (PCP), other referrals, or both, when applicable;
 - 2. A physical examination, including a health history, performed no more than seven (7) days before admission or within forty-eight (48) hours after admission;
 - 3. Admitting diagnosis;
 - 4. Results of all consultative evaluations of the beneficiary and appropriate findings by clinical and other staff involved in the care of the beneficiary;
 - 5. Documentation of complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia;
 - 6. Properly executed informed consent forms for procedures and treatments specified by the medical staff, or specified by federal or state law when applicable, which require written patient consent;
 - 7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, vital signs, and other information necessary to monitor the beneficiary's condition;
 - 8. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;
 - 9. Final diagnosis with completion of medical records within thirty (30) days following discharge.

215.040 Benefit Limit in Outpatient Diagnostic Laboratory and Radiology/Other Procedures 11-1-26

- A. Arkansas Medicaid limits claims payment for outpatient diagnostic laboratory services and radiology/other services per beneficiary twenty-one (21) years of age or older.
 - 1. The benefit limits are based on the State Fiscal Year (SFY: July 1 through June 30).

2. Diagnostic laboratory services benefits are limited to five hundred dollars (\$500) per SFY, and radiology/other services benefits are limited to five hundred dollars (\$500) per SFY.
3. Radiology/other services include without limitation diagnostic X-rays, ultrasounds, and electronic monitoring or machine tests, such as electrocardiograms (ECG or EKG).
4. 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 annual caps.

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

- B. The benefit limits apply to payments made to the following providers, individually or in any combination: outpatient hospitals, independent laboratories, physicians, osteopaths, podiatrists, certified nurse-midwives (CNMs), nurse practitioners (NP), physician assistants, clinical nurse specialists, and ambulatory surgical centers (ASCs).
- C. Requests for extensions of both benefits are considered for beneficiaries who require supportive treatment for maintaining life.
- D. Extension of the benefits are automatic for patients whose primary diagnosis for the service furnished is in the following list:
 1. Malignant neoplasm ([View ICD Codes](#));
 2. HIV infection and AIDS ([View ICD Codes](#));
 3. Renal failure ([View ICD Codes](#));
 4. Pregnancy* ([View ICD Codes](#)): or
 5. Opioid Use Disorder (OUD) when treated with Medication Assisted Treatment (MAT). ([View ICD OUD Codes](#)) Designated laboratory tests will be exempt from the laboratory services benefit limit when the diagnosis is OUD ([View Laboratory and Screening Codes](#)).
- E. Magnetic Resonance Imaging (MRI) is exempt from the radiology/other services state fiscal year (SFY) benefit limit. Medical necessity for each MRI must be documented in the beneficiary's medical record. (Refer to Section 270.000 for billing information.)
- F. Cardiac catheterization procedures are exempt from the SFY outpatient diagnostic laboratory services benefit limit and the SFY radiology/other benefit limit. Medical necessity for each procedure must be documented in the beneficiary's medical record.
- G. Benefit limits generally do not apply on outpatient diagnostic laboratory services or radiology/other services for beneficiaries under twenty-one (21) in the Child Health Services/Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

216.130 Family Planning Coverage Information

11-1-26

- A. Medicaid encourages reproductive health and family planning by reimbursing physicians, nurse practitioners, certified nurse midwives, physician assistants, clinical nurse specialists, clinics, and hospitals for a comprehensive range of family planning services.
 1. Family planning services do not require a PCP referral.
 2. Family planning services benefits are in addition to the Medicaid beneficiary's other medical benefits, when providers bill the services specifically as family planning services.
 3. Abortion is not a family planning service in the Arkansas Medicaid Program.

- B. Hospitals may participate in the Family Planning Services Program by providing the services listed in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 to Medicaid beneficiaries of childbearing age.
- C. Hospitals preferring not to provide family planning services may share other sources for these services with their patients. Listed providers include:
 - 1. Local Department of Health units
 - 2. Obstetricians and gynecologists
 - 3. Nurse practitioners
 - 4. Certified nurse-midwives
 - 5. Rural Health Clinics
 - 6. Federally Qualified Health Centers
 - 7. Family planning clinics
 - 8. Physician Assistants
 - 9. Clinical Nurse Specialists
- D. Complete billing instructions for family planning services are contained in Sections 216.100-216.110, 216.130-216.132, 216.500-216.515, and 216.540-216.550 of this manual.

TOC not required**212.000 Scope****6-7-1011-1-
26**

Hyperalimentation services are provided to beneficiaries at their place of residence. "Place of residence" is defined as the beneficiary's own dwelling, an apartment, a relative's home or a boarding home. Hyperalimentation services in the beneficiary's place of residence ~~may be~~ only covered ~~only~~ when the therapy is determined to be medically necessary for the ~~patient~~ beneficiary and is prescribed by a physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist (hereinafter referred to as the "prescribing provider").

Hospitalization is required to initiate parenteral and enteral, ~~(sole source)~~ nutrition.

Enteral (sole source) nutrition therapy must meet the criteria listed above and be the sole source of nutrition ~~in order~~ to be covered by Medicaid.

The request for prior authorization for therapy must be submitted on the form DMS-2615. [View or print form DMS-2615 and instructions for completion.](#) The prescribing ~~physician provider~~ must document the beneficiary's diagnosis and brief medical history that supports the medical necessity of the requested nutritional therapy services. The prescription must specify the frequency, the route, the product name, volume, and duration of the requested nutritional therapy.

Documentation describing the beneficiary's or caregiver's training in catheter care; solution preparation, and infusion technique ~~to ensure the prescribed therapy can be provided safely and effectively in the beneficiary's place of residence~~ must be available upon request. This documentation is required to ensure the prescribed therapy can be provided safely and effectively in the beneficiary's place of residence Hospital records documenting the initiation of parenteral or enteral ~~(sole source)~~ nutrition must be submitted with the initial prior authorization request for these services.

~~The~~ Arkansas Medicaid ~~Program~~ does not cover enteral (sole source) nutrition therapy hyperalimentation services for patients residing in a long term care facility. Enteral (sole source) nutrition therapy services are included in the per diem amount paid to long term care facilities. Arkansas Medicaid does cover parenteral nutrition therapy services through the Hyperalimentation Program for long term care facility residents who are Medicaid beneficiaries.

222.000 Request for Prior Authorization**8-1-2111-1-
26**

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. [View or print form DMS-2615 and instructions for completion.](#) ~~The~~ is form must be signed and dated by the prescribing ~~physician provider~~.

The request for prior authorization ~~will be~~ reviewed by ~~the~~ Department of Human Services (DHS) or its designated QIO vendor. The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, additional information may be requested (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.).

222.100 Approvals of Prior Authorization Requests**8-1-2111-1-
26**

When the PA request is approved, a prior authorization control number will be assigned. Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing ~~physician-provider~~ documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve (12) months. The effective date of the prior authorization will be the date the patient ~~will~~ begins therapy or the day following the last day of the previous authorization approval.

223.000 Pre-Approval of Hyperalimentation Services

8-1-2111-1-
26

When an eligible Medicaid beneficiary ~~will be~~ discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation before the anticipated discharge date. [View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting pre-approval for hyperalimentation.](#)

When approved, a prior authorization number ~~will be~~ assigned and will be effective for thirty (30) days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within ~~the~~ thirty (30) days ~~from the anticipated discharge date~~, the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request with a prescription signed by the prescribing ~~physician-provider~~, ~~prior before~~ the end date of the pre-approval.

A pre-approval of hyperalimentation services does not guarantee payment.

232.000 Rate Appeal Review Process

10-13-0311-
1-26

A provider may request ~~reconsideration review~~ of a ~~P~~program ~~decision- rate policy or procedure~~ by writing to the ~~Assistant~~ Director, Division of Medical Services (DMS). ~~Refer to Section I, 110.400 of the manual to get instructions for requesting a review.~~ ~~This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.~~

~~When the provider disagrees with the decision of the Assistant Director of the Division of Medical Services, the provider may appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairperson.~~

~~The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

242.310 Completion of CMS-1500 Claim Form

9-1-1411-1-
26

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician/provider .
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.

Field Name and Number	Instructions for Completion
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. - On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. - Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the services was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF ~~PHYSICIAN~~ PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC not required**212.000 Scope****11-1-26**

Hyperalimentation services are provided to beneficiaries at their place of residence. "Place of residence" is defined as the beneficiary's own dwelling, an apartment, a relative's home or a boarding home. Hyperalimentation services in the beneficiary's place of residence is only covered when the therapy is determined to be medically necessary for the beneficiary and is prescribed by a physician, physician assistant, advanced practice registered nurse (APRN), or clinical nurse specialist (hereinafter referred to as the "prescribing provider").

Hospitalization is required to initiate parenteral and enteral (sole source) nutrition.

Enteral (sole source) nutrition therapy must meet the criteria listed above and be the sole source of nutrition to be covered by Medicaid.

The request for prior authorization for therapy must be submitted on the form DMS-2615. [View or print form DMS-2615 and instructions for completion.](#) The prescribing provider must document the beneficiary's diagnosis and brief medical history that supports the medical necessity of the requested nutritional therapy services. The prescription must specify the frequency, the route, the product name, volume, and duration of the requested nutritional therapy.

Documentation describing the beneficiary's or caregiver's training in catheter care; solution preparation, and infusion technique must be available upon request. This documentation is required to ensure the prescribed therapy can be provided safely and effectively in the beneficiary's place of residence. Hospital records documenting the initiation of parenteral or enteral (sole source) nutrition must be submitted with the initial prior authorization request for the services.

Arkansas Medicaid does not cover enteral (sole source) nutrition therapy hyperalimentation services for patients residing in a long term care facility. Enteral (sole source) nutrition therapy services are included in the per diem amount paid to long term care facilities. Arkansas Medicaid does cover parenteral nutrition therapy services through the Hyperalimentation Program for long term care facility residents who are Medicaid beneficiaries.

222.000 Request for Prior Authorization**11-1-26**

Requests for prior authorization originate with the provider. The provider is responsible for obtaining the required medical information and necessary prescription information needed for completion of the Request for Prior Authorization and Prescription Form. [View or print form DMS-2615 and instructions for completion.](#) The form must be signed and dated by the prescribing provider. The request for prior authorization is reviewed by Department of Human Services (DHS) or its [designated QIO vendor](#). The documentation submitted with the prior authorization request must support the medical necessity of the requested nutritional therapy. In some cases, additional information may be requested (i.e., original prescription, records from the hospitalization initiating nutritional therapy, nutritional assessment to establish medical necessity for nutritional therapy, etc.).

222.100 Approvals of Prior Authorization Requests**11-1-26**

When the PA request is approved, a prior authorization control number will be assigned. Prior authorization approvals are authorized for a maximum of six (6) months (180 days) or for the life of the prescription, whichever is shorter. If the prescribing provider documents the beneficiary's condition is chronic and unlikely to change, a prior approval may be authorized for a maximum of twelve (12) months. The effective date of the prior authorization will be the date the patient begins therapy or the day following the last day of the previous authorization approval.

223.000 Pre-Approval of Hyperalimentation Services**11-1-26**

When an eligible Medicaid beneficiary will be discharged from the inpatient setting with the continuation of hyperalimentation services in the home, a provider may request a pre-approval for hyperalimentation before the anticipated discharge date. [View or print contact information to obtain the DHS or its designated vendor step-by-step process for requesting pre-approval for hyperalimentation.](#)

When approved, a prior authorization number is assigned and will be effective for thirty (30) days. The provider must not bill for hyperalimentation services prior to the date of discharge or bill for services on the same dates of service as the inpatient stay.

If the beneficiary is not discharged within thirty (30) days from the anticipated discharge date, the pre-approval will be void.

When continuation of the therapy is required past the initial thirty (30) day pre-approval, the provider must submit a recertification for prior authorization request with a prescription signed by the prescribing provider, before the end date of the pre-approval.

A pre-approval of hyperalimentation services does not guarantee payment.

232.000 Rate Review Process**11-1-26**

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to [Section I, 110.400 of the manual](#) to get instructions for requesting a review.

242.310 Completion of CMS-1500 Claim Form**11-1-26**

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.

Field Name and Number	Instructions for Completion
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.

Field Name and Number	Instructions for Completion
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.

Field Name and Number	Instructions for Completion
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring provider.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB?	Not required.
\$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. - On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. - Some providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the services was an emergency.

Field Name and Number	Instructions for Completion
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PROVIDER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

TOC required**240.100 Definition of Terms****11-1-26**

Acute care hospital means a hospital that:

- A. Is licensed by the Department of Health under § 20-9- 19 201 et seq., as a general hospital or a surgery and general medical care hospital; and
- B. Is enrolled as a provider with the Arkansas Medicaid Program.

Birth hospital means a hospital in this state or in a border state that:

- A. Is licensed as a general hospital;
- B. Provides obstetrics services; and
- C. Is enrolled as a provider with the Arkansas Medicaid program.

Care coordination coaches mean those individuals who establish relationships with their clients to ensure effective participation in the Rural Life360 program. Coaches may work under various titles including peer specialists, peer counselors, family support workers, and home visitors. They work directly with clients and their families to improve their life skills to be physically, socially, and emotionally healthy to live successfully in their communities.

Community services mean any resource or services provided by public or private organizations to community residents to assist with a particular social need such as mental health or counseling or health-related needs including housing or food or job training and employment. It may also include other general services or programs offered through libraries or other local government funding that benefit the community.

Evidence-based home visitation means a home visitation program that is one of the models recognized by the U.S. Department of Health and Human Services to be effective in improving maternal and child health.

Healthcare coverage means coverage provided under this subchapter through either an individual qualified health plan (QHP), a risk-based provider organization, managed care organization, employer health insurance coverage, or the fee-for-service (FFS) Medicaid program.

High-risk pregnancy means a pregnancy with a diagnostic code of supervision of high-risk pregnancy, as evidenced by a physician, certified nurse midwife (CNM), clinical nurse specialist (CNS), or Advanced Practice Registered Nurse (APRN) referral. High-risk diagnosis includes medical and/or social risk.

Home-visiting means an evidence-based program that provides direct support and intensive care coordination of services for clients served by Maternal Life360s with the goals of improving maternal and infant health outcomes, promoting child development and school readiness, connecting families to needed community resources and supports, and increasing a family's education and earning potential.

HRSN reimbursable cost means time-limited expenses to enable a client to access services or supports to meet an identified HRSN allowable under Life360. These must be identified through a Health-Related Social Needs (HRSN) screening, or the client's engagement with the care coordinator, and are transitional in nature. Examples include housing safety inspections, pest control, security deposit and first month's rent that is required to obtain a lease on an apartment or home, and nutritional instruction for disease control/prevention.

HRSN screening means a standardized way of capturing a Life360 client's health-related social needs to determine any needs or barriers a client may experience at the time of screening. For example, an individual may have trouble paying rent on time and be at risk of losing their apartment. A pregnant individual may experience difficulty going to her doctor's appointments due to not having a car and lack resources for food. Information gathered through the screening may be used to help inform care coordination plans or referrals to community services and supports.

Individual Qualified Health Plan (QHP) means an individual health insurance benefit plan offered in the health insurance marketplace to provide coverage in Arkansas that covers only essential health benefits as defined by Arkansas rule and 45 C.F.R. § 156.110 and any federal insurance regulations.

Intensive care coordination is an umbrella term for a collaborative process in which a care coordinator or others assess, plan, implement, coordinate, monitor and evaluate the options, services and supports required to meet the client's health and HRSN needs. It is characterized by advocacy, communication, and resource management, and promotes quality interventions and outcomes. In addition to addressing medical services, care coordination coaches ensure that clients have safe housing, employment, education, financial stability, and emotional/mental wellness.

Mental illness refers to clients with a diagnosis of one or more of the following: neurodevelopmental disorders, schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, and personality disorders.

Non-Reimbursable Community Contribution (NRCC) means a payment, including an in-kind payment, for goods or services provided to a client to assist the client with meeting a HRSN identified in the client's person-centered action plan but is not a HRSN-reimbursable cost or reimbursable through other Medicaid funds under the Life360 HOME agreement. NRCC may include rent or utility costs for example, or excluded categories (i.e. job preparation expenses such as clothing or personal care). The identification of sources of NRCC and the types of NRCC provided shall be included in the application and in program reports.

Partner agreement means the sub contractual agreement executed between the Life360 and its partner subrecipients. The subrecipient has its performance measured against whether the objectives of the program as outlined in the Life360 HOME agreement between DHS and the Life360 are met; has responsibility for programmatic decision-making; and uses funds to carry out the program by providing goods or supports to clients. Subrecipients are identified in the application and in programmatic and financial reports. Additional subrecipients can be requested during the program period by contacting the Life360 program manager at DHS. Subrecipients will need to be updated into the Life360 HOME agreement.

Person-Centered Action Plan (PCAP) means a plan completed by the Life360 that identifies a client's strengths, preferences and includes information from the HRSN screen and additional information gathered from the client through meetings and any other tools utilized by the program. The PCAP includes short and longer-term goals and objectives to address the client's HRSN and other personal goals as well as details on how and what services and supports will be obtained, a crisis plan, and documentation of progress on goals and successes and barriers encountered. The PCAP is updated as the client meets goals, circumstances change, or ~~the sets~~ new goals are set.

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Rural area means an Arkansas county where a hospital designated as a critical access hospital or participant in the Small Rural Hospital Improvement Program is located or an Arkansas county with a population of fifty_-thousand (50,000) or less.

Small rural hospital means a critical access hospital or a general hospital that:

- A. Is ~~located~~ in a rural area;
- B. Has fifty (50) or fewer staffed beds; and
- C. Is enrolled as a provider in the Arkansas Medicaid program.

Health-Related Social Needs (HRSN) means conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Veteran means a person who served in the active military, naval, or air service and who was discharged or released there from as verified by DD214 documentation.

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PROPOSED

TOC required

203.020 Documentation of Services

117-1-2647

Home Health providers must maintain the following records for patients of all ages:

- A. Signed and dated patient assessments and plans of care, including applicable physical therapy evaluations and treatment plans, ~~when applicable;~~
- B. Signed and dated case notes and progress notes from each scheduled visit by nurses, aides, physical therapists, and physical therapy assistants;
- C. In addition to any case notes and progress notes required in (B), sSigned and dated documentation of *pro re nata* (PRN) visits, which must include the following:
 1. The medical justification for each such unscheduled visit;
 2. The patient's vital signs and symptoms;
 3. The observations of and measures taken by agency staff and reported to the physician;
 4. The physician's comments, observations, and instructions;
- D. Documented Verification, ~~by means of physician or approved non-physician practitioner documentation that there was a~~ face-to-face encounter with the beneficiary occurred that meets the following requirements:
 1. ~~For the initiation of home health services, t~~The face-to-face encounter must be related to the primary reason the beneficiary requires home health services to initiate the services and must occur within ~~the ninety (90) days before or the~~irty (30) days after the start of the services;
 2. ~~For the initiation of medical equipment, t~~The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment to initiate it, and must occur no more than six (6) months prior to the start of services~~delivery of the equipment;~~
 3. The face-to-face encounter may be conducted by one of the following practitioners:
 - a. The primary care ~~physician~~provider;
 - b. A nurse practitioner or clinical nurse specialist working in collaboration with the primary care ~~physician~~provider, when the nurse practitioner or clinical nurse specialist is someone other than the PCP;
 - c. A certified nurse midwife by the scope of practice;
 - d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for ~~whom~~ the physician takes full responsibility; ~~The service is not considered to be separate from the physician's service.~~
 - e. ~~For beneficiaries admitted to home health immediately after an acute or post-acute stay, t~~The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay;
 4. The allowed non-physician, non-PCP practitioner performing the face-to-face encounter must communicate the clinical findings of ~~the~~ eat encounter to the ordering PCP or attending provider~~physician~~. These clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record;

5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the ~~physician-PCP or attending provider~~ ordering the services must:
 - a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required timeframes prior to the start of home health services_i.
 - b. Indicate-Document the practitioner who conducted the encounter, and the date of the encounter_i.
 6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter_i.
- ED.** No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the ~~primary care physician-PCP~~ or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in DC.3. ~~with the exception of~~except for nurse-midwives_i.
- FE.** Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications_i.
- GF.** Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention_i.
- HG.** The registered nurse's instructions to home health aides, detailing the aide's duties at each visit_i.
- IH.** The registered nurse's notes (or applicable physical therapist's ~~when applicable~~) notes from supervisory visits.

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits

117-1-265

- A. For ~~clients-beneficiaries~~ twenty-one (21) years of age or older, APRN services provided in a physician office, an APRN office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30)_i.

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. APRN services in the office, patient's home, or nursing facility_i
2. Physician services in the office, patient's home, or nursing facility_i
3. Rural health clinic (RHC) encounters_i
4. Medical services furnished by a dentist_i
5. Medical services furnished by an optometrist_i
6. Certified nurse-midwife services_i
7. Federally qualified health center (FQHC) encounters_i
8. Clinical nurse specialist services in the office, patient's home, or nursing facility_i
9. Physician Assistant services_i

The established benefit limit does not apply to ~~clients-beneficiaries~~ under age twenty-one (21).

~~Office-v~~Visits coded with the following diagnosis codes do not count against the limit: malignant neoplasm, renal failure, HIV/AIDS, pregnancy, or opioid use disorder when the service is part of

~~a Medication Assisted Treatment Plan. obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.~~

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.330 Family Planning Coverage Information

4-1-2411-1-
26

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners and clinical nurse specialists for a comprehensive range of family planning services_;
1. Family planning services do not require a PCP referral_;
 2. Medicaid beneficiaries' receive family planning ~~services~~ benefits are in addition to their other medical benefits_; when providers bill the services specifically as family planning services_;
 3. Family planning prescriptions are unlimited and do not count toward the benefit limit_;
 4. Extension of benefits is not available for family planning services_;
 5. Abortion is not a family planning service in the ~~Arkansas~~ Medicaid Program_;
- B. Other than full coverage aid categories, ~~Arkansas~~ Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information_;
- C. Nurse practitioners and clinical nurse specialist who want ~~desiring~~ to participate in the Medicaid Family Planning Services Program may do so by providing ~~provide~~ the services listed in Sections 214.321 through 241.333 to ~~Medicaid~~ beneficiaries of childbearing age_;
- D. Nurse practitioners and clinical nurse specialists preferring who do not want to provide family planning services may refer their patients to other providers. DHS County Offices maintain listsings of qualified local and area providers. qualified to provide family planning services. ~~Listed family planning~~ providers include:
1. ~~Arkansas Local~~ Department of Health ~~local health~~ units_;
 2. Obstetricians and gynecologists_;
 3. Physicians_;
 4. Rural Health Clinics_;
 5. Federally Qualified Health Centers_;
 6. Family planning clinics_;
 7. Physician Assistants_;
 8. Certified Nurse-Midwives_;
 9. Clinical Nurse Specialists_;
 10. Advanced Practice Registered Nurses_;
- E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting_;

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04);~~;~~
 2. 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 an inpatient stay. On the outpatient claim, [see LARC billing combinations for billing codes](#). Ensure the applicable NDC code is submitted on the claim;~~;~~
 3. ~~Physician Performing Provider~~ charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The ~~physician provider~~ can also charge for the LARC device, if provided by the Physician. [See LARC billing combinations for billing codes](#);~~;~~
 4. The ~~applicable~~ 340-B rules and modifiers to the LARC code combinations apply;~~;~~
~~when applicable.~~
- F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

232.000 [Rate Appeal Review Process](#)

10-13-0311-
1-26

A provider may request ~~reconsideration review~~ of a program ~~decision rate policy or procedure~~ by writing to the ~~Assistant~~ Director, Division of Medical Services (DMS). [Refer to Section I, 110.400 of the manual to get instructions for requesting a review.](#) ~~This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.~~

~~If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing rate review panel established by the Director of the Division of Medical Services. The rate review panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) management staff, who will serve as chairman.~~

~~The request for review by the rate review panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The rate review panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

TOC required

203.020 Documentation of Services

11-1-26

Home Health providers must maintain the following records for patients of all ages:

- A. Signed and dated patient assessments and plans of care, including applicable physical therapy evaluations and treatment plans;
- B. Signed and dated case notes and progress notes from each scheduled visit by nurses, aides, physical therapists, and physical therapy assistants;
- C. In addition to any case notes and progress notes required in (B), signed and dated documentation of *pro re nata* (PRN) visits, which must include the following:
 1. The medical justification for each such unscheduled visit;
 2. The patient's vital signs and symptoms;
 3. The observations of and measures taken by agency staff and reported to the physician;
 4. The physician's comments, observations, and instructions;
- D. Documented verification, a face-to-face encounter with the beneficiary occurred that meets the following requirements:
 1. The face-to-face encounter must be related to the primary reason the beneficiary requires home health services to initiate the services and must occur within ninety (90) days before or thirty (30) days after the start of the services;
 2. The face-to-face encounter must be related to the primary reason the beneficiary requires the medical equipment to initiate it, and must occur no more than six (6) months prior to the delivery of the equipment;
 3. The face-to-face encounter may be conducted by one of the following practitioners:
 - a. The primary care provider;
 - b. A nurse practitioner or clinical nurse specialist working in collaboration with the primary care provider, when the nurse practitioner or clinical nurse specialist is someone other than the PCP;
 - c. A certified nurse midwife by the scope of practice;
 - d. A physician assistant under the supervision of the primary care physician according to Arkansas Medicaid Physician Policy. Physician assistant services are services furnished according to AR Code § 17-105-101 (2012) and rules and regulations issued by the Arkansas State Medical Board. Physician assistants are dependent medical practitioners practicing under the supervision of the physician, for whom the physician takes full responsibility;
 - e. The attending acute or post-acute physician for beneficiaries admitted to home health immediately after an acute or post-acute stay;
 4. The allowed non-physician, non-PCP practitioner performing the face-to-face encounter must communicate the clinical findings of the encounter to the ordering PCP or attending provider. The clinical findings must be incorporated into a written or electronic document included in the beneficiary's medical record;
 5. To assure clinical correlation between the face-to-face encounter and the associated home health services, the PCP or attending provider ordering the services must:
 - a. Document that the face-to-face encounter which is related to the primary reason the patient requires home health services occurred within the required

- timeframes prior to the start of home health services;
- b. Document the practitioner who conducted the encounter, and the date of the encounter;
- 6. The face-to-face encounter may occur through telemedicine when applicable to the program manual of the performing provider of the encounter;
- D. No payment may be made for medical equipment, supplies, or appliances to the extent that a face-to-face encounter requirement would apply as durable medical equipment (DME) under the Medicare program unless the PCP or allowed non-physician practitioner documents a face-to-face encounter with the beneficiary consistent with the requirements. The face-to-face encounter may be performed by any of the practitioners described in C.3. except for nurse-midwives;
- E. Copies of current signed and dated plans of care, including interim and short-term plan-of-care modifications;
- F. Copies of plans of care, PCP referrals, case notes, etc., for all previous episodes of care within the period of required record retention;
- G. The registered nurse's instructions to home health aides, detailing the aide's duties at each visit;
- H. The registered nurse's notes or applicable physical therapist's notes from supervisory visits.

214.210**Advanced Practice Registered Nurse (APRN) Services Benefit Limits****11-1-26**

- A. For beneficiaries twenty-one (21) years of age or older, APRN services provided in a physician office, an APRN office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30);

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. APRN services in the office, patient's home, or nursing facility;
2. Physician services in the office, patient's home, or nursing facility;
3. Rural health clinic (RHC) encounters;
4. Medical services furnished by a dentist;
5. Medical services furnished by an optometrist;
6. Certified nurse-midwife services;
7. Federally qualified health center (FQHC) encounters;
8. Clinical nurse specialist services in the office, patient's home, or nursing facility;
9. Physician Assistant services.

The established benefit limit does not apply to beneficiaries under age twenty-one (21).

Visits coded with the following diagnosis codes do not count against the limit: malignant neoplasm, renal failure, HIV/AIDS, pregnancy, or opioid use disorder when the service is part of a Medication Assisted Treatment Plan.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.330 Family Planning Coverage Information**11-1-26**

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing nurse practitioners and clinical nurse specialists for a comprehensive range of family planning services:
1. Family planning services do not require a PCP referral;
 2. Medicaid beneficiaries receive family planning benefits in addition to their other medical benefits when providers bill the services specifically as family planning services;
 3. Family planning prescriptions are unlimited and do not count toward the benefit limit;
 4. Extension of benefits is not available for family planning services;
 5. Abortion is not a family planning service in the Medicaid Program;
- B. Other than full coverage aid categories, Medicaid covers one basic family planning examination and three periodic family planning visits per client, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information;
- C. Nurse practitioners and clinical nurse specialist who want to participate in the Medicaid Family Planning Services Program may provide the services listed in Sections 214.321 through 214.333 to beneficiaries of childbearing age;
- D. Nurse practitioners and clinical nurse specialists who do not want to provide family planning services may refer their patients to other providers. DHS County Offices maintain lists of qualified local and area providers. Listed family planning providers include:
1. Local Department of Health units;
 2. Obstetricians and gynecologists;
 3. Physicians;
 4. Rural Health Clinics;
 5. Federally Qualified Health Centers;
 6. Family planning clinics;
 7. Physician Assistants;
 8. Certified Nurse-Midwives;
 9. Clinical Nurse Specialists;
 10. Advanced Practice Registered Nurses;
- E. Effective 1/1/24, providers are allowed to bill for Long-Acting Reversible Contraception (LARC) devices and professional services immediately after childbirth and during post-partum, while the beneficiary remains in an inpatient setting;

Billing guidelines:

1. The Hospital should continue to bill the inpatient stay on an inpatient claim (CMS-1450, formerly UB-04);
2. 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 an inpatient stay. On the outpatient claim, [see LARC billing combinations for billing codes](#). Ensure the applicable NDC code is submitted on the claim;
3. Performing Provider charges can be billed for insertion and removal on a professional claim (CMS-1500), in addition to their delivery charges. The provider

can also charge for the LARC device, if provided by the Physician. [See LARC billing combinations for billing codes](#);

4. The applicable 340-B rules and modifiers to the LARC code combinations apply;
- F. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

232.000 Rate Review Process

11-1-26

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to [Section I](#), 110.400 of the manual to get instructions for requesting a review.

PROPOSED

TOC required

213.110 Physician Assistant Services

10-15-0911-
1-26

Physician assistant services are services furnished according to ~~Arkansas Statute A.C.A.~~ 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for ~~whom~~ the physician takes full responsibility. ~~The service is not considered to be separate from the physician's service.~~

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

241.000 Fluoride Varnish Treatment

2-1-2211-1-
26

~~Arkansas~~ Medicaid ~~will expand~~ ~~coverages~~ for fluoride varnish application, ~~ADA code, to when furnished by~~ physicians, physician assistants, clinical nurse specialists, and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

[View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.](#)

The online training course can be accessed at <http://ar.train.org>. The provider ~~will need to~~ must maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

243.000 Family Planning Coverage Information

11-1-1011-
1-26

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, certified nurse midwives, nurse practitioners, clinics, and hospitals for a comprehensive range of family planning services.
 1. Family planning services do not require a PCP referral.
 - ~~2.~~ Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
 - ~~32.~~ Abortion is not a family planning service in the ~~Arkansas~~ Medicaid Program.
- B. Physicians, physician assistants, clinical nurse specialists, certified nurse midwives, and advanced practice registered nurses desiring to can participate in the Medicaid Family Planning Services Program ~~may do so~~ by providing the services listed in Sections 243.300 through 243.500 to Medicaid beneficiaries of childbearing age.
- C. Physicians, physician assistants, clinical nurse specialists, certified nurse midwives, and advanced practice registered nurses preferring who do not to provide family planning services may refer their patients to other providers. ~~DHS County Offices maintain listings of local and area providers qualified to provide family planning services. Listed providers include: Beneficiaries and providers may contact the~~ **Beneficiary Support Center to receive lists of the following family planning provider types:**
 1. Arkansas Local Department of Health ~~local health~~ units
 2. Obstetricians and gynecologists
 3. Nurse practitioners

4. Rural Health Clinics
5. Federally Qualified Health Centers
6. Family planning clinics
7. Physician Assistants
8. Clinical Nurse Specialists
9. Certified Nurse-Midwives

- D. Complete billing instructions for family planning services are located in Sections 292.550 through 292.553 of this manual.

273.000 — Rate Appeal Process

10-13-03

~~A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.~~

~~If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. This panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.~~

~~The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.~~

292.741 Behavioral Health Screen

**1-1-23 11-1-
26**

A physician, physician's assistant, clinical nurse specialist, 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 billed under the minor'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.

TOC required**213.110 Physician Assistant Services****11-1-26**

Physician assistant services are services furnished according to A.C.A. 17-105-101 and rules and regulations issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for whom the physician takes full responsibility.

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

241.000 Fluoride Varnish Treatment**11-1-26**

Medicaid covers for fluoride varnish application when furnished by physicians, physician assistants, clinical nurse specialists, and nurse practitioners who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

[View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.](#)

The online training course can be accessed at <http://ar.train.org>. The provider must maintain a copy of the certificate of completion in their files and submit a copy to the Arkansas Medicaid provider enrollment unit.

243.000 Family Planning Coverage Information**11-1-26**

- A. Arkansas Medicaid encourages reproductive health and family planning by reimbursing physicians, physician assistants, clinical nurse specialists, certified nurse midwives, nurse practitioners, clinics, and hospitals for a comprehensive range of family planning services.
 - 1. Family planning services do not require a PCP referral. Medicaid beneficiaries' family planning services benefits are in addition to their other medical benefits, when providers bill the services specifically as family planning services.
 - 2. Abortion is not a family planning service in the Medicaid Program.
- B. Physicians, physician assistants, clinical nurse specialists, certified nurse midwives, and advanced practice registered nurses can participate in the Medicaid Family Planning Services Program by providing the services listed in Sections 243.300 through 243.500 to Medicaid beneficiaries of childbearing age.
- C. Physicians, physician assistants, clinical nurse specialists, certified nurse midwives, and advanced practice registered nurses who do not provide family planning services may refer their patients to other providers. Beneficiaries and providers may contact the [Beneficiary Support Center](#) to receive lists of the following family planning provider types:
 - 1. Local Department of Health units
 - 2. Obstetricians and gynecologists
 - 3. Nurse practitioners
 - 4. Rural Health Clinics
 - 5. Federally Qualified Health Centers
 - 6. Family planning clinics
 - 7. Physician Assistants
 - 8. Clinical Nurse Specialists

9. Certified Nurse-Midwives
- D. Complete billing instructions for family planning services are located in Sections 292.550 through 292.553 of this manual.

292.741 Behavioral Health Screen**11-1-26**

A physician, physician's assistant, clinical nurse specialist, 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 billed under the minor'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.

SECTION II -PHYSICIAN ASSISTANT

CONTENTS

TOC required

200.000 PHYSICIAN ASSISTANT GENERAL INFORMATION

201.000 Arkansas Medicaid Requirements for Participation in the Physician Assistant Program 11-1-26

The Arkansas Medicaid Program enrolls Physician Assistants for participation in the Physician Assistant Program. Physician Assistant Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must be licensed by the state authority in the state in which services are furnished.
- B. The following documents must be submitted with the provider application and Medicaid contract:
 1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
 2. Providers have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must inform the Medicaid Provider Enrollment Unit of his or her Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
 3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 Electronic Signatures 11-1-26

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 Group Providers 11-1-26

Group providers of Physician Assistant services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program. Since physician assistants must be supervised by a physician, there is not a physician assistant group provider type. However, physician assistants may affiliate with other group providers including physician groups, FQHCs, and RHCs.

If a Physician Assistant is a member of a group, each individual Physician Assistant and the group must both enroll according to the following criteria:

- A. Each individual Physician Assistant within the group must enroll following the criteria established in Section 201.000.
- B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled Physician Assistant within the group.

201.200 Providers in Arkansas and Bordering States 11-1-26

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

Services rendered by physician assistants in the six (6) border states must comply with the scope of practice and limitations in privileges specified in Arkansas Law. In addition, physician assistants are only allowed to perform services authorized by their supervising physicians. Their supervising physicians must also be actively enrolled as participating Arkansas Medicaid providers.

201.210 Providers in Non-Bordering States

11-1-26

A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. **View the provider enrollment application on the Health Care Provider Portal. View or print Provider Enrollment Unit Contact information.** In addition, the physician assistant's supervising physicians must be actively enrolled with Arkansas Medicaid.

B. Limited services providers remain enrolled for one (1) year.

1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
2. During the enrollment period, the provider may file any subsequent claims directly with the Medicaid fiscal agent.
3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Physician Assistant

11-1-26

The Physician Assistant must be licensed as a Physician Assistant by the state in which services are furnished.

202.000 Medical Records Physician Assistants are Required to Keep

11-1-26

A. Physician Assistants are required to keep the following records and, upon request, furnish the records to authorized representatives of the Department of Human Services/Division of Medical Services, the Office of Medicaid Inspector General, the state Medicaid Fraud Control Unit and representatives of the Centers for Medicare and Medicaid Services (CMS) or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG):

1. History and physical examinations;
2. Chief complaint on each visit;
3. Tests and results;

4. Diagnoses;
 5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation;
 6. Signature or initials of the Physician Assistant after each visit;
 7. Copies of records pertinent to services delivered by the Physician Assistant and billed to Medicaid;
 8. Records must include the service date of each service billed to Medicaid.
- B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards.
- C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.
- D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).
- E. All documentation must be made available to representatives of the above authorized individuals and agencies during normal business hours at the time an audit is conducted. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, additional documentation will be accepted for thirty-five (35) days after the date of the recoupment letter. Additional documentation will not be accepted later.

203.000 The Physician Assistant's Role in Home Health Services 11-1-26

Physician Assistants must meet the home health rules and regulations found in **Section II of the Medicaid Home Health Provider Manual.**

203.100 The Physician Assistant's Role in the Pharmacy Program 11-1-26

Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Physician Assistant with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

A Physician Assistant who prescribes medication to an Arkansas Medicaid Beneficiary must do so in accordance with **Section II of the Arkansas Medicaid Pharmacy Provider Manual.**

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. **View or print contact information for the DHS designated Pharmacy Vendor.**

203.200 The Physician Assistant's Role in the Child Health Services (EPSDT) Program 11-1-26

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their twenty-first (21st) birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care.

including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services delivered.

Physician Assistants who choose to enroll as PCPs must follow the rules set forth in the **Child Health Services (EPSDT) provider manual**.

203.300 The Physician Assistant's Role in the ARKids First-B Program

11-1-26

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas' uninsured children. The health care delivery network for ARKids First-B Program is ConnectCare. ConnectCare is the Primary Care Case Management (PCCM) Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First-B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are like EPSDT screens. Except for routine newborn care, preventive health screens must be performed by the primary care physician (PCP) or referred by the PCP to an appropriate provider for screening. If a Physician Assistant receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP.

Physician Assistants enrolled as a Medicaid provider and interested in participating in the ARKids First-B program can **download the ARKids First-B manual** for further information.

203.400 Physician Assistant's Role in Early Intervention Reporting for Children from Birth to Three Years of Age

11-1-26

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six (36) months of age. Health care providers, including Physician Assistants, offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

A. A child must be referred if he or she is age birth to three (3) years and meets one or more of the following criteria:

1. Developmental delay – a delay of twenty-five percent (25%) or greater in one (1) of the following areas of development:
 - a. Physical (gross/fine motor).
 - b. Cognitive.
 - c. Communication.
 - d. Social or emotional.
 - e. Adaptive and self-help skills.
2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
 - a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
 - b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly, and macrocephaly.
 - c. Maternal Acquired Immune Deficiency Syndrome (AIDS).
 - d. Sensory impairments such as visual or hearing disorders.

- B. The Division of Developmental Disabilities Services (DDS) within the Department of Human Services is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

203.500 The Physician Assistant's Role in Family Planning Services

11-1-26

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by Physician Assistants and other providers. Medicaid beneficiaries' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

- A. Refer to Sections 214.321 through 214.333 of this manual for family planning coverage information.
- B. Refer to Sections 252.430 and 252.431 of this manual for family planning services special billing instructions and procedure codes.

203.600 The Physician Assistant's Role in Hospital Services

11-1-26

- A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)
- B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed Physician Assistant, a certified nurse-midwife, a nurse practitioner, or a dentist with hospital staff privileges.
- C. DHS or its designated vendor reviews all inpatient hospital transfers, and all inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.**

- D. Hospital claims are also subject to review by the Arkansas Medicaid Medical Director for the Medicaid Program.
1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to Physician Assistants for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
 2. Physician Assistants and hospitals may not bill a Medicaid beneficiary for a service Medicaid has denied due to not meeting medical necessity criteria.
 3. Physician Assistants and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 Reserved

11-1-26

204.000 Role of Quality Improvement Organization (QIO)

11-1-26

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective, efficient, and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to ensure that federal

payment for services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a Physician Assistant being subject to pre-payment review of up to one hundred percent (100%) of admissions. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction

11-1-26

The Medical Assistance (Medicaid) Program is designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in **Section I** of this manual. All Medicaid benefits are based upon medical necessity. **See the Glossary of this manual** for “medical necessity” definition.

212.000 Physician Assistant

11-1-26

A Physician Assistant, as applicable to this program, is a licensed professional who meets the participation requirements and enrollment criteria for physician assistant as defined by the state licensing authority.

Physician Assistant services are services furnished according to Arkansas Code 17-105-101 and rules issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility.

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

The Physician Assistant engages in collaborative decision-making about the health care needs of patients with the physician under which direct supervision is vested. Collaboration with health professionals and others occurs in making decisions about other health care needs. The Physician Assistant plans and initiates health care programs as a member of the health care team. The supervising physician is directly accountable and responsible for the quality of care provided.

213.000 Scope

11-1-26

The scope of the Physician Assistant Program includes Medicaid covered services provided by pediatrics, family, obstetric-gynecologic (women’s health care), and gerontological Physician Assistants in accordance with state and federal regulations.

Services provided through the Physician Assistant Program include:

- A. Assessment and diagnostic services
- B. Development and implementation of treatment plans
- C. Evaluation of beneficiary outcomes
- D. Referrals to appropriate providers when the health status of the beneficiary requires additional diagnostic and treatment services
- E. Other services as authorized by the supervising physician or services as defined in the physician assistant’s delegation agreement with the supervising physician

214.000 Coverage**11-1-26**

Many Physician Assistant services covered by the Arkansas Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services beneficiaries may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 for information about covered Physician Assistant services with restrictions, benefit limits, or both.

214.100 Exclusions**11-1-26**

Exclusions are those services not covered in the Medicaid Physician Assistant Program and any covered services furnished by a Physician Assistant that are not within their scope of practice as defined by the state licensing authority. Services are not covered when provided by an employed or contracted Physician Assistant who is not enrolled in the Physician Assistant Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented by diagnoses that certify medical necessity.

214.200 General Physician Assistant Services**11-1-26**

- A. Services provided by a Physician Assistant include initial visits and established patient visits for:
1. Diagnosis and evaluation.
 2. Treatment services.
 3. Health management services for prevention and early intervention.
 4. Appropriate referrals to other health care providers for diagnostic and treatment services.
- B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Physician Assistant Services Benefit Limits**11-1-26**

- A. For clients twenty-one (21) years of age or older, PA services provided in a physician office, a PA office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. PA services in the office, patient's home, or nursing facility;
2. Physician services in the office, patient's home or nursing facility;
3. Rural health clinic (RHC) encounters;
4. Medical services furnished by a dentist;
5. Medical services furnished by an optometrist;
6. Certified nurse-midwife services;
7. Federally qualified health center (FQHC) encounters;
8. APRN services in the office, patient's home, or nursing facility; and
9. Clinical Nurse Specialist services.

The established benefit limit does not apply to beneficiaries under twenty-one (21) years of age.

Obstetric office visits are not counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.300 **Reserved** **11-1-26**

214.310 **Reserved** **11-1-26**

214.320 **Reserved** **11-1-26**

214.321 **Family Planning Services for Women in Aid Category 61, PW** **11-1-26**

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services through the last day of the month in which the sixtieth (60th) day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 **Family Planning Coverage Information** **11-1-26**

A. Medicaid encourages reproductive health and family planning by reimbursing Physician Assistants for a comprehensive range of family planning services.

1. Family planning services do not require a PCP referral.
2. Medicaid beneficiaries receive family planning services benefits in addition to their other medical benefits, when providers bill the services specifically as family planning services.
3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
4. Extension of benefits is not available for family planning services.
5. Abortion is not a family planning service in the Medicaid Program.

B. Other than full coverage aid categories, Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.

C. Physician Assistants participating in the Medicaid Family Planning Services Program provide the services listed in Sections 214.321 through 214.333 to beneficiaries of childbearing age.

D. Physician Assistants who do not want to provide family planning services may refer their patients to other providers. DHS County Offices maintain local and area qualified family planning provider lists. Listed providers include:

1. Local Department of Health units;
2. Obstetricians and gynecologists;
3. Physicians;
4. Rural Health Clinics;
5. Federally Qualified Health Centers;
6. Family planning clinics;

7. Physicians; and
8. Certified Nurse-Midwives.

E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Physician Assistant Basic Family Planning Visit

11-1-26

Medicaid covers one (1) basic family planning visit per beneficiary per state fiscal year (July 1 through June 30). The basic visit comprises the following:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight, and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam.
 2. The full range of contraceptive methods available.
 3. HIV and STD prevention.
- C. Prescription for any contraceptives selected by the beneficiary.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test.
 2. Hemoglobin and hematocrit.
 3. Sickle cell screening.
 4. Urinalysis testing for albumin and glucose.
 5. Papanicolaou (PAP) smears for cervical cancer.
 6. Testing for sexually transmitted infections.

214.332 Physician Assistant Periodic Family Planning Visit

11-1-26

Medicaid covers three (3) periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure, and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception

11-1-26

- A. Prescription and Non-Prescription Contraceptives:
 1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
 2. Medicaid covers non-prescription contraceptives as a family planning benefit when a physician or other licensed practitioner with prescriptive authority writes a prescription for them.
- B. Contraceptive Implant Systems:
 1. Medicaid covers the contraceptive implant systems, including implants and supplies.
 2. Medicaid covers insertion, removal, and removal with reinsertion.
- C. Intrauterine Device (IUD):

1. Medicaid pays for IUDs as a family planning benefit.
2. Medicaid reimburses physicians that supply the IUD at the time of insertion.
3. Medicaid pays physicians for IUD insertion and removal.

D. Medroxyprogesterone Acetate:

Medicaid covers medroxyprogesterone acetate injections for birth control.

E. Sterilization:

1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
2. Refer to Sections 252.430 through 252.431 of this manual for procedure codes and billing instructions for family planning services.

214.400 Reserved

11-1-26

214.500 Laboratory and X-Ray Services Referral Requirements

11-1-26

A Physician Assistant referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, and include in the order, pertinent supplemental diagnosis supporting the need for the test(s).

- A. Diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring Physician Assistant to establish medical necessity.
- B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.
- C. Physician Assistants must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
- D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
- E. The following ICD diagnosis codes may not be utilized (**View ICD Codes.**).

Medicaid regulations regarding collection, handling, and conveyance of specimens are as follows:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in circumstances including:
 - 1 drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or,
 - 2 collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

View or print the procedure codes for Physician Assistant services.

NOTE: The P codes listed within the procedure codes hyperlink are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, a collection fee may not be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits **11-1-26**

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

Please refer to Section 229.100 through 229.130 of the **Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual** for information about requesting extension of benefits.

All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).

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 (2) new annual caps.

View or print the essential health benefit procedure codes.

214.600 Obstetrical Services **11-1-26**

The Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW beneficiaries are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the sixtieth (60th) postpartum day falls.

214.610 Covered Physician Assistant Obstetrical Services **11-1-26**

Covered Physician Assistant obstetrical services may be provided when medically necessary. These services are *limited* to antepartum and postpartum care. Appropriate referrals must be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High-Risk Pregnancy **11-1-26**

The Physician Assistant may provide risk management services authorized under the agreement with their supervising physician. If a Physician Assistant does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional, and psychosocial assessment by a Physician Assistant or a registered nurse on the Physician's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form includes:
 - a. Medical history,
 - b. Menstrual history, and
 - c. Pregnancy history.
2. Nutritional assessment includes:
 - a. 24-hour diet recall,
 - b. Screening for anemia, and
 - c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) units per pregnancy

B. Case Management Services

Case management services are provided by a Physician Assistant, APRN, Clinical Nurse Specialist, licensed social worker, or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational, and other services (such as locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, and rescheduling the appointment if needed).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. The case management contact may be with the patient, other professionals, family, or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, physician assistant, APRN, Clinical Nurse Specialist, public health nurse, nutritionist, or health educator) include:

1. Pregnancy;
2. Labor and delivery;
3. Reproductive health;
4. Postpartum care;
5. Nutrition in pregnancy; and
6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors and development of a nutritional care plan; and
2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors and development of a social work care plan
2. Social work plan follow-up, appropriate intervention, and referrals

Maximum: Six (6) units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be made by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours when there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in **Section 252.450**.

214.700 Reserved

11-1-26

214.710 Inpatient Services

11-1-26

Physician Assistant inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary.

Inpatient services are subject to QIO review for medical necessity whether the Physician Assistant's supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Physician Assistant and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

All medical staff must provide inpatient service in compliance with Section 6 of the **Arkansas State Board of Health Rules for Hospitals and Related Institutions in Arkansas**.

214.711 Medicaid Utilization Management Program (MUMP)

11-1-26

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under one (1) year of age, are subject to this policy. Medicaid beneficiaries under one (1) year of age at the time of admission are exempt from the MUMP policy for dates of service before their first

birthday. Refer to item “E” below for the procedure to follow when a child’s first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

- A. Medicaid will reimburse hospitals for up to seven (7) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.
- B. If the attending Physician Assistant’s supervising physician determines the patient should not be discharged by the eighth (8th) day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.

- C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.
- D. When a Medicaid beneficiary reaches one (1) year of age during an inpatient stay, the days from the admission date through the day before the patient’s birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient’s birthday is the first day of the seven (7) days not requiring MUMP certification. If the stay continues beyond the seventh (7th) day (inclusive) of the patient’s first birthday, hospital staff must apply for MUMP certification of the additional days.
- E. Additional extensions may be requested as needed.
- F. Reconsideration reviews of denied extensions may be requested by sending the medical record to the **QIO contractor** through regular mail or expedited by overnight express. The hospital will be notified by the next working day.
- G. Calls to extend days may be made at any point from the seventh (7th) day of stay through discharge. However, the provider must accept financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.
- H. Inpatient stays for bone marrow, liver, heart, lung, skin, and pancreas and kidney transplant procedures are excluded from this review program.
- I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of seven (7) days or less, to ensure that medical necessity for the services is substantiated.
- J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still inpatient, the hospital may request retrospective review of those days already used past the original seven (7) for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original seven (7) allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refiled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

- K. Claims submitted without extension will result in automatic denials of any days billed beyond the seventh (7th) day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

- L. If a patient is transferred from one (1) facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.
- M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code to be reimbursed.
- N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days because the beneficiary has private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, or similar, then post-certification of days past the original seven (7) days may be obtained by the following procedures:
 - 1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
 - 2. Include a note requesting post-certification, the full name of the requester, and a phone number where the requester may be reached.Upon receipt of the denial copy and the provider request, a coordinator will call the provider to obtain certification information.
- O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.712 Evaluation and Management**11-1-26**

- A. Medicaid covers Physician Assistant evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses Physician Assistants for medically necessary discharge day management unless the Physician Assistant evaluation and management services for that day are included in another service, or unless the Physician Assistant does not customarily bill private-pay patients for discharge day management.
- B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the Physician Assistant sees the patient.
- C. The Medicaid Program will recover payments to Physician Assistants for inpatient evaluation and management services on days when the hospital's inpatient claims are denied (or would be denied, if filed) for:
 - 1. Exceeding benefit limits;
 - 2. Failure to pre-certify inpatient days, when applicable; or
 - 3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures**11-1-26**

Hospital reimbursement for inpatient services covered by Medicaid includes the non-professional components (technical components) such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to Physician Assistants and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed for diagnosing and treating an inpatient hospital beneficiary. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits 11-1-26

- A. An annual benefit limit of twenty-four (24) medically necessary days per state fiscal year (July 1 through June 30) applies for Medicaid beneficiaries twenty-one (21) years of age and older. Upon the twenty-fifth day, any medically necessary inpatient days will be covered at a lower rate of four hundred dollars (\$400) per day.
- B. Inpatient hospital benefit limits do not apply for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 11-1-26

Outpatient hospital Physician Assistant services are divided into two (2) types of service for the purpose of coverage and reimbursement determination.

214.721 Emergency Services 11-1-26

Physician Assistant outpatient hospital visits are covered as an emergency when the beneficiary's medical condition constitutes an emergency medical condition. (Refer to the **Glossary of this manual** for the definition of emergency services.)

Services not considered as emergency services are covered with primary care physician approval, or the beneficiary may be billed for the services.

214.722 Non-Emergency Services 11-1-26

Coverage of non-emergency Physician Assistant services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology, and anatomical laboratory procedures.

214.800 Occupational, Physical, and Speech-Language Therapy 11-1-26

Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries. Please refer to the **Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services manual**.

214.900 Procedures for Obtaining Extension of Benefits 11-1-26

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 11-1-26

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting. Please refer to Section 229.100 through 229.130 of the **Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual** for information about requesting extension of benefits.

214.940 Administrative Reconsiderations and Appeals 11-1-26

- 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.

214.950 Reserved **11-1-26**

214.952 Continued Services During the Appeal Process **11-1-26**

Services may be continued pending the outcome of an appeal in accordance with **Section 161.500 of this Manual.**

215.000 Fluoride Varnish Treatment **11-1-26**

Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

View or print the procedure codes for Physician Assistant services.

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at <http://ar.train.org>. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 PRIOR AUTHORIZATION

221.000 Procedure for Obtaining Prior Authorization **11-1-26**

- A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.
- B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.**
 - 1. Prior authorization determinations are in accordance with established medical or administrative criteria combined with the professional judgment of physician advisors.
 - 2. Payment for prior-authorized services is in accordance with federal regulations.
- C. Prior authorization of service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 Post-Procedural Authorization **11-1-26**

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age or older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 **11-1-26**

- A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.
- B. The following post-procedural authorization process must be followed when obtaining an authorization number.
1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**
 2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **View or print contact information to obtain dates of eligibility.**
 3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
 4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization **11-1-26**

Prescription drugs are available for reimbursement under the Medicaid Program when prescribed by a Physician Assistant with prescriptive authority. Certain prescription drugs may require prior authorization. The prescriber is responsible for requesting and obtaining the prior authorization. Information may be obtained from DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor prescription drug information.**

The following information is available:

- A. Prescription drugs requiring prior authorization.
- B. Criteria for drugs requiring prior authorization.
- C. Forms to be completed for prior authorization.
- D. Procedures required of the prescriber to request and obtain prior authorization.

221.300 Procedures that Require Prior Authorization **11-1-26**

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement

11-1-26

Medicaid reimbursement for Physician Assistant services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules**11-1-26**

Medicaid provides fee schedules on the DMS website. **View the fee schedules.** The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage, or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Review Process**11-1-26**

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to Section I, 110.400 of the manual to get instructions for requesting a review.

250.000 BILLING PROCEDURES**252.000 Introduction to Billing****11-1-26**

Physician Assistant providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures**252.100 Reserved****11-1-26****252.110 Billing Protocol for Computed Tomographic Colonography (CT)****11-1-26**

A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

View or print the procedure codes for Physician Assistant services.

B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Physician Assistant, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved**11-1-26****252.130 Special Billing Instructions****11-1-26**

A. Use the following procedure codes for billing.

View or print the procedure codes for Physician Assistant services.

B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.

C. If authorized by the supervising physician, a physician assistant shall be:

1. Identified as the rendering provider in billing and claims processes when the physician assistant rendered the medical services to the Medicaid beneficiary; and
2. Allowed to file claims as the billing provider for medical services provided to a Medicaid beneficiary by the physician assistant.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology

11-1-26

The following Molecular Pathology codes require prior authorization from DHS or its designated vendor. See Sections 221.000 through 221.300 for prior authorization procedures.

View or print the procedure codes for Physician Assistant services.

252.132 Special Billing Requirements for Lab and X-Ray Services

11-1-26

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

- A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code.
- B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.

C. All other billing requirements must be met for payment to be approved.

View or print the procedure codes for Physician Assistant services.

252.200 Reserved

11-1-26

252.210 National Place of Service (POS) Codes

11-1-26

Electronic and paper claims now require the same National Place of Service code.

<u>Place of Service</u>	<u>POS Codes</u>
<u>Inpatient Hospital</u>	<u>21</u>
<u>Off-Campus Outpatient Hospital</u>	<u>19</u>
<u>On-Campus Outpatient Hospital</u>	<u>22</u>
<u>Office</u>	<u>11</u>
<u>Patient's Home</u>	<u>12</u>
<u>Mobile Unit</u>	<u>15</u>
<u>Nursing Facility</u>	<u>32</u>
<u>Skilled Nursing Facility</u>	<u>31</u>
<u>Ambulance</u>	<u>41</u>

<u>Place of Service</u>	<u>POS Codes</u>
<u>Other Locations</u>	<u>99</u>
<u>Telehealth</u>	<u>02</u>
<u>Telehealth in Patient's Home</u>	<u>10</u>

252.300 Billing Instructions – Paper Claims Only**11-1-26**

Bill Medicaid for Physician Assistant services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help the Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if required information is omitted.

Forward completed claim forms to the Claims Department. **View or print the Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form**11-1-26**

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
<u>1. (type of coverage)</u>	<u>Not required.</u>
<u>1a. INSURED'S I.D. NUMBER</u> <u>(For Program in Item 1)</u>	<u>Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.</u>
<u>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</u>	<u>Beneficiary's or participant's last name and first name.</u>
<u>3. PATIENT'S BIRTH DATE</u>	<u>Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.</u>
<u>SEX</u>	<u>Check M for male or F for female.</u>
<u>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</u>	<u>Required if insurance affects this claim. Insured's last name, first name, and middle initial.</u>
<u>5. PATIENT'S ADDRESS (No., Street)</u>	<u>Optional. Beneficiary's or participant's complete mailing address (street address or post office box).</u>
<u>CITY</u>	<u>Name of the city in which the beneficiary or participant resides.</u>
<u>STATE</u>	<u>Two-letter postal code for the state in which the beneficiary or participant resides.</u>
<u>ZIP CODE</u>	<u>Five-digit zip code; nine digits for post office box.</u>
<u>TELEPHONE (Include Area Code)</u>	<u>The beneficiary's or participant's telephone number or the number of a reliable message, contact, or emergency telephone.</u>

Field Name and Number	Instructions for Completion
6. <u>PATIENT RELATIONSHIP TO INSURED</u>	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. <u>INSURED'S ADDRESS (No., Street)</u> <u>CITY</u> <u>STATE</u> <u>ZIP CODE</u> <u>TELEPHONE (Include Area Code)</u>	Required if insured's address is different from the patient's address.
8. <u>RESERVED</u>	Reserved for NUCC use.
9. <u>OTHER INSURED'S NAME (Last name, First Name, Middle Initial)</u> a. <u>OTHER INSURED'S POLICY OR GROUP NUMBER</u> b. <u>RESERVED</u> <u>SEX</u> c. <u>RESERVED</u> d. <u>INSURANCE PLAN NAME OR PROGRAM NAME</u>	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial. Policy or group number of the insured individual. Reserved for NUCC use. Not required. Reserved for NUCC use. Name of the insurance company.
10. <u>IS PATIENT'S CONDITION RELATED TO:</u> a. <u>EMPLOYMENT? (Current or Previous)</u> b. <u>AUTO ACCIDENT?</u> <u>PLACE (State)</u> c. <u>OTHER ACCIDENT?</u> d. <u>CLAIM CODES</u>	Check YES or NO. Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place. Required when an accident other than automobile is related to the services. Check YES or NO. The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. <u>INSURED'S POLICY GROUP OR FECA NUMBER</u> a. <u>INSURED'S DATE OF BIRTH</u> <u>SEX</u>	Not required when Medicaid is the only payer. Not required. Not required.

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
b. <u>OTHER CLAIM ID NUMBER</u>	<u>Not required.</u>
c. <u>INSURANCE PLAN NAME OR PROGRAM NAME</u>	<u>Not required.</u>
d. <u>IS THERE ANOTHER HEALTH BENEFIT PLAN?</u>	<u>When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one (1) box can be marked.</u>
12. <u>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</u>	<u>Enter "Signature on File," "SOF" or legal signature.</u>
13. <u>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</u>	<u>Enter "Signature on File," "SOF" or legal signature.</u>
14. <u>DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</u>	<u>Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident.</u> <u>Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.</u>
15. <u>OTHER DATE</u>	<u>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</u> <u>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</u> <u>454 Initial Treatment</u> <u>304 Latest Visit or Consultation</u> <u>453 Acute Manifestation of a Chronic Condition</u> <u>439 Accident</u> <u>455 Last X-Ray</u> <u>471 Prescription</u> <u>090 Report Start (Assumed Care Date)</u> <u>091 Report End (Relinquished Care Date)</u> <u>444 First Visit or Consultation</u>
16. <u>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</u>	<u>Not required.</u>
17. <u>NAME OF REFERRING PROVIDER OR OTHER SOURCE</u>	<u>Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.</u>
17a. (blank)	<u>Not required.</u>
17b. NPI	<u>Enter NPI of the referring physician.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
18. <u>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</u>	<u>When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.</u>
19. <u>ADDITIONAL CLAIM INFORMATION</u>	<u>Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.</u>
20. <u>OUTSIDE LAB?</u>	<u>Not required.</u>
<u>\$ CHARGES</u>	<u>Not required.</u>
21. <u>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</u>	<u>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</u> <u>Use "9" for ICD-9-CM.</u> <u>Use "0" for ICD-10-CM.</u> <u>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</u> <u>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</u>
22. <u>RESUBMISSION CODE</u>	<u>Reserved for future use.</u>
<u>ORIGINAL REF. NO.</u>	<u>Any data or other information listed in this field does not and will not adjust, void, or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.</u>
23. <u>PRIOR AUTHORIZATION NUMBER</u>	<u>The prior authorization or benefit extension control number if applicable.</u>
24A. <u>DATE(S) OF SERVICE</u>	<u>The "from" and "to" dates of service for each billed service. Format: MM/DD/YY.</u> <u>1. On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month.</u> <u>2. Some providers may bill on the same claim detail for two (2) or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.</u>
B. <u>PLACE OF SERVICE</u>	<u>Enter the appropriate place of service code. See Section 252.200 for codes.</u>
C. <u>EMG</u>	<u>Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
<u>D. PROCEDURES, SERVICES, OR SUPPLIES</u>	
<u>CPT/HCPCS</u>	<u>Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.</u>
<u>MODIFIER</u>	<u>Modifier(s) if applicable.</u>
<u>E. DIAGNOSIS POINTER</u>	<u>Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.</u>
<u>F. \$ CHARGES</u>	<u>The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.</u>
<u>G. DAYS OR UNITS</u>	<u>The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.</u>
<u>H. EPSDT/Family Plan</u>	<u>Enter E if the services resulted from a Child Health Services (EPSDT) screening or referral.</u>
<u>I. ID QUAL</u>	<u>Not required.</u>
<u>J. RENDERING PROVIDER ID #</u>	<u>Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or</u>
<u>NPI</u>	<u>Enter NPI of the individual who furnished the services billed for in the detail.</u>
<u>25. FEDERAL TAX I.D. NUMBER</u>	<u>Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.</u>
<u>26. PATIENT'S ACCOUNT N O.</u>	<u>Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."</u>
<u>27. ACCEPT ASSIGNMENT?</u>	<u>Not required. Assignment is automatically accepted by the provider when billing Medicaid.</u>
<u>28. TOTAL CHARGE</u>	<u>Total of Column 24F—the sum all charges on the claim.</u>
<u>29. AMOUNT PAID</u>	<u>Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.</u>
<u>30. RESERVED</u>	<u>Reserved for NUCC use.</u>

<u>Field Name and Number</u>	<u>Instructions for Completion</u>
<u>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</u>	<u>The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.</u>
<u>32. SERVICE FACILITY LOCATION INFORMATION</u>	<u>If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.</u>
<u>a. (blank)</u>	<u>Not required.</u>
<u>b. (blank)</u>	<u>Not required.</u>
<u>33. BILLING PROVIDER INFO & PH #</u>	<u>Billing provider's name and complete address. Telephone number is requested but not required.</u>
<u>a. (blank)</u>	<u>Enter NPI of the billing provider or</u>
<u>b. (blank)</u>	<u>Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.</u>

252.400 Special Billing Procedures**252.410 Clinic or Group Billing****11-1-26**

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) Physician Assistant in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

[View or print the procedure codes for Physician Assistant services.](#)

252.420 Evaluations and Management**252.421 Initial Visit****11-1-26**

The American Medical Association's *Current Procedures Terminology* (CPT) codes should be used only for the first visit of a new patient. Each subsequent visit should be billed using an established patient code. A distinction is made in CPT codes for new or established patients for office visits, home visits, nursing facility visits and emergency room visits. Refer to the latest edition of the CPT for detailed information.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service)**11-1-26**

View or print the procedure codes for Physician Assistant services.

Procedure code must be used by Physician Assistants when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

252.423 Inpatient Hospital Visits**11-1-26**

Each Physician Assistant is limited to billing one (1) day of care for each inpatient hospital covered day, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management**11-1-26****View or print the procedure codes for Physician Assistant services.**

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits**11-1-26**

The appropriate CPT procedure codes should be used when billing for Physician Assistant visits in a nursing facility.

252.426 Specimen Collections**11-1-26**

The policy regarding collection, handling, and conveyance of specimens is:

A. Reimbursement will not be made for specimen handling fees.

B. A specimen collection fee may be allowed only in circumstances including:

- 1 drawing a blood sample through venipuncture (for example, inserting into a vein a needle with syringe or vacutainer to draw the specimen); or
- 2 collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

View or print the procedure codes for Physician Assistant services.**252.428 Services Not Considered a Separate Service from an Office Visit****11-1-26**

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

View or print the procedure codes for Physician Assistant services.**252.429 Health Examinations for ARKids First-B Beneficiaries and Medicaid Beneficiaries Under Age 21****11-1-26**

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes**11-1-26**

A. Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures.** Laboratory procedure codes covered for family planning are listed in **Section 252.431**.

B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and a claim for payment to be sure that all criteria have been met. **View or print form DMS-615 (English) and the checklist. View or print form DMS-615 (Spanish) and the checklist.**

C. The procedure code table located within the hyperlink below explains the family planning visit services payable to Physician Assistants.

NOTE: The procedure codes with the modifiers indicated in the table denote the Arkansas Medicaid description.

View or print the procedure codes for Physician Assistant services.

D. The procedure code table explains family planning codes payable to Physician Assistants. Use the FP modifier for family planning services.

252.431 Family Planning Laboratory Procedure Codes**11-1-26**

Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

A. The procedure code table within the hyperlink contains family planning laboratory procedure codes.*

View or print the procedure codes for Physician Assistant services.

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year; are payable only to pathologists and independent labs; require FP modifier only.

B. Laboratory codes payable to non-hospital-based Physician Assistants.

The procedure code table contains laboratory services payable to non-hospital-based Physician Assistants.

C. Laboratory codes payable to hospital-based Physician Assistants.

The procedure code table within the hyperlink describes the **laboratory services payable to hospital-based Physician Assistants.**

252.438 National Drug Codes (NDCs)

11-1-26

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with *Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT)* codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the **DHS contracted Pharmacy vendor** website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC.	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer or distributor.

Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
<u>LABELER</u>	<u>PRODUCT</u>	<u>PACKAGE</u>
<u>CODE</u>	<u>CODE</u>	<u>CODE</u>
(5 digits)	(4 digits)	(2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected and denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

<u>10-digit FDA NDC on PACKAGE</u>	<u>Required 11-digit NDC</u> <u>(5-4-2) Billing Format</u>
<u>12345 6789 1</u>	<u>12345678901</u>
<u>1111-2222-33</u>	<u>01111222233</u>
<u>01111 456 71</u>	<u>01111045671</u>

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected and denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

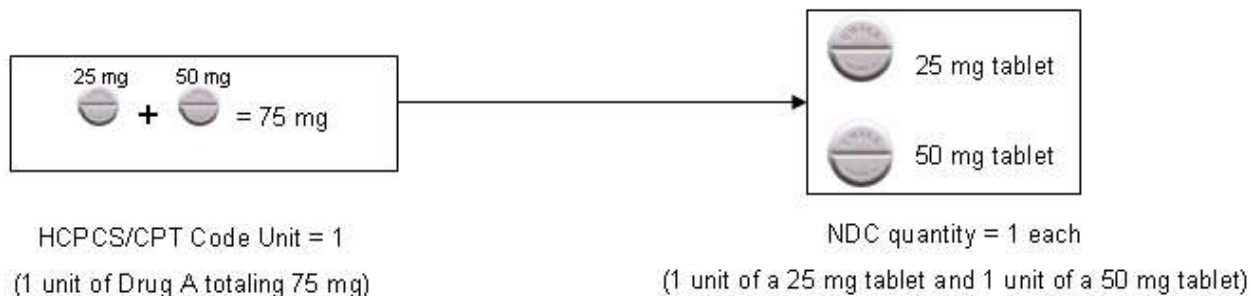
I. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

Example 1: The HCPCS/CPT code may specify up to seventy-five milligrams (75mg) of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is provided

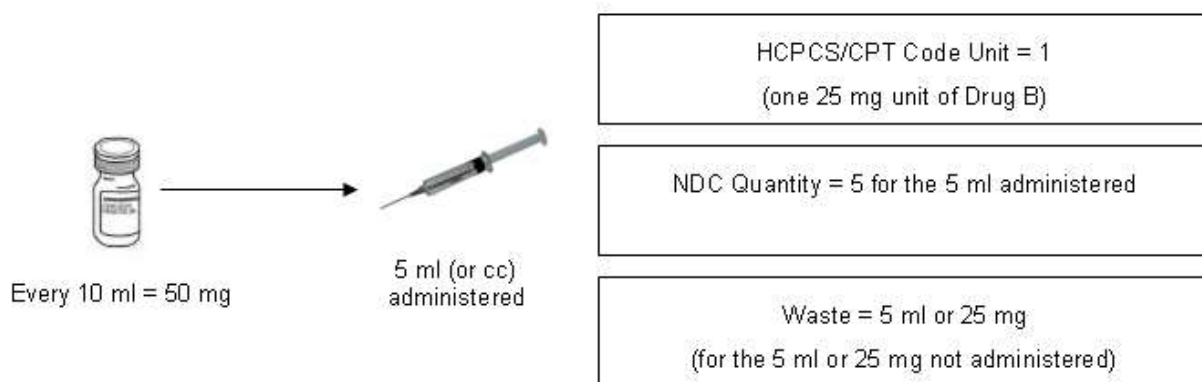
two (2) oral tablets, one at twenty-five milligrams (25mg) and one at fifty milligrams (50mg), the HCPCS/CPT code unit would be 1 (one (1) total of seventy-five milligrams (75mg)) in the example whereas the NDC quantity would be 1 each (one (1) unit of the twenty-five milligram (25mg) tablet and one (1) unit of the fifty milligram (50mg) tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of five milliliters (5ml) or cc of a product that was fifty milligrams (50mg) per ten milliliters (10ml) of a ten milliliter (10ml) single-use vial, the HCPCS/CPT code unit would be 1 (one (1) unit of twenty-five milligrams (25mg)) whereas the NDC quantity would be 5 (five milliliters (5ml)). In this example, five milliliters (5ml) or twenty-five milligrams (25mg) would be documented as wasted. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – submit via paper claim
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

Diagram 6

24. A.		DATE(S) OF SERVICE				B.		C.		D. PROCEDURES, SERVICES, OR SUPPLIES (Specify Unusual Circumstances)				E.		F.		G.		H.		I.		J.	
		From		To		PLACE OF SERVICE		EMG		CPT/HCPCS		MODIFIER		DIAGNOSIS POINT		\$ CHARGES		UNIT UNITS		TIME PERIOD		ID		RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY																				
1	N4	12345678912	UN	1.00				11		Z1234	KP		1		25	00	1							123456789	
2	N4	01111222223	UN	1.00						Z1234	KQ		1		25	00	1							123456789	
3	N4	44444455506	ML	3.0				11		Z1234	KQ		1		75	00	3							123456789	
4	N4	44444455506	ML	2.0				11		Z1234	JW		1		50	00	2							123456789	
5																									
6																									
SEE GENERAL INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS		SEE INSTRUCTIONS	

II. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC

invoices showing purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials**11-1-26**

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

View or print the procedure codes for Physician Assistant services.

- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
1. **Single-Use Vials:** If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
 2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
 3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.440 Reserved**11-1-26****252.441 Family/Group Psychotherapy****11-1-26**

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

View or print the procedure codes for Physician Assistant services.

Procedure codes are payable when the place of service is the beneficiary’s home, the physician’s office, a hospital, or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes**11-1-26**

The technical component radiology procedure codes listed on the Physician Assistant fee schedule are payable when performed in the office place of service (11) if the Physician Assistant provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Physician Assistant fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Physician Assistant providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections

11-1-26

Physician Assistants billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

View or print the procedure codes for Physician Assistant services.

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine

11-1-26

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

View or print the procedure codes for Physician Assistant services.

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administration fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved

11-1-26

252.446 Reserved

11-1-26

252.447 Reserved

11-1-26

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs

11-1-26

Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by qualified physicians, physician assistants, or advanced practice registered nurses who are enrolled in an Arkansas Medicaid Program in which MAT services are rendered. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

View or print the procedure codes for Physician Assistant services.

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the **DHS contracted Pharmacy vendor website**.

252.449 Influenza Virus Vaccine

11-1-26

View or print the procedure codes for Physician Assistant services.

A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.

For ARKids First-B beneficiaries, use modifier **TJ**.

B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for ages three (3) years of age and older.

1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.

2. For ARKids First-B beneficiaries, use modifier **TJ**.

3. For individuals nineteen (19) years of age and older, no modifier is necessary.

C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals five through forty-nine (5-49) years of age through 49 who are not pregnant.

1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.

2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.

3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.

D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.

For ARKids First-B beneficiaries, use modifier **TJ**.

E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.

1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.

2. For ARKids First-B beneficiaries, use modifier **TJ**.

3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy

11-1-26

Covered Physician Assistant obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A Physician Assistant may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the Physician Assistant employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered as one (1) service and are limited to thirty-two (32) cumulative units.

View or print the procedure codes for Physician Assistant services.

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.452 Newborn Care

11-1-26

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn is responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) is responsible for the charges incurred by the newborn.

View or print the procedure codes for Physician Assistant services.

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a Physician Assistant.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **View or print Provider Assistance Center contact information.**

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids First-A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First-B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment

11-1-26

View or print the procedure codes for Physician Assistant services.

The American Dental Association (ADA) procedure code is covered by the Medicaid. The code is payable for beneficiaries under twenty-one (21) years of age. Topical Fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)). View a form CMS-1500 sample form.

252.454 Tobacco Cessation Products and Counseling Services

11-1-26

A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the **DHS Contracted Pharmacy Vendor website** or in the **Prescription Drug Program Prior Authorization Criteria**.

View or print the procedure codes for Physician Assistant services.

*Exempt from PCP referral requirements.

*(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

B. Four (4) Counseling visits per state fiscal year.

C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.

D. Can be billed in addition to an office visit or EPSDT.

E. Sessions do not require a PCP referral.

F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section B above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at **Be Well Arkansas Referral Form**.

252.455 Physical Therapy Services Billing

11-1-26

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are not payable to the Physician Assistant. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. **See Glossary - Section IV -** for definitions of "group" and "individual" as they relate to therapy services.

View or print the procedure codes for Physician Assistant services.

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) **11-1-26**

The following CPT procedure codes are covered for Medicaid beneficiaries.

View or print the procedure codes for Physician Assistant services.

252.457 Procedures That Require Prior Authorization **11-1-26**

- A. The following procedure code requires prior authorization by the DHS or its designated vendor. (See Section 220.000 of this manual for prior authorization instructions.)
- B. The following Molecular Pathology codes require **prior authorization from DHS or its designated vendor.**

View or print the procedure codes for Physician Assistant services.

252.460 Outpatient Hospital Services**252.461 Emergency Services** **11-1-26**

The appropriate CPT procedure codes should be used when billing the Physician Assistant's emergency service visits in an outpatient hospital setting.

252.462 Non-Emergency Services **11-1-26**

Procedure code should be billed for a non-emergency Physician Assistant visit.

View or print the procedure codes for Physician Assistant services.

252.465 Observation Status **11-1-26**

When claims are filed for services provided to a patient in "observation status," Physician Assistants must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Physician Assistants must also follow the guidelines and definitions in *Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

- A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the Physician Assistant should consider the patient an outpatient meaning, the patient is an outpatient unless the Physician Assistant's supervising physician has admitted him or her as an inpatient).
- B. If the Physician Assistant or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the Physician Assistant's supervising physician has not yet formally admitted the patient.
- C. Medicaid also deems a patient admitted to inpatient status once the patient has remained in the hospital for twenty-four (24) consecutive hours, even if the Physician Assistant, the supervising physician, or the hospital had no prior expectation of a stay of that or greater duration

252.466 Billing Examples **11-1-26**

The following table gives examples of appropriate Physician Assistant claims for several common hospital scenarios. In the table, instructions under the headings “PHYSICIAN ASSISTANT MAY BILL...” do not necessarily include all services that the Physician Assistant may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

Arkansas Medicaid Observation Status Policy Illustration

<u>PATIENT IS ADMITTED TO OBSERVATION</u>	<u>PATIENT IS</u>	<u>PHYSICIAN ASSISTANT MAY BILL FOR TUESDAY SERVICES:</u>	<u>PHYSICIAN ASSISTANT MAY BILL FOR WEDNESDAY SERVICES:</u>
<u>Tuesday, 3:00 PM</u>	<u>Still in Observation Wednesday, 3:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Appropriate level of Initial Hospital Care</u>
<u>Tuesday, 3:00 PM</u>	<u>Discharged Wednesday, 12:00 PM (noon)</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Observation care Discharge Day Management</u>
<u>Tuesday, 3:00 PM</u>	<u>Discharged Wednesday, 4:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Appropriate level of Initial Hospital Care</u>
<u>Tuesday, 3:00 PM, after outpatient surgery</u>	<u>Discharged Wednesday, 10:00 AM</u>	<u>Outpatient surgery</u>	<u>No evaluation and Management Services</u>
<u>Tuesday, 3:00 PM, after exam in Emergency Department—emergency or non-emergency</u>	<u>Discharged Tuesday, 7:00 PM</u>	<u>Appropriate level of Initial Observation Care</u>	<u>Not Applicable; Patient was Discharged Tuesday</u>

252.470 Prior Authorization Control Number

11-1-26

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare

11-1-26

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement

11-1-26

Services that have been denied by Medicare with the explanation “Services Prior to Medicare Entitlement” may be filed with Medicaid. These services should be filed for processing on the

CMS-1500 claim form and forwarded to the Inquiry Unit. **View or print the Inquiry Unit contact information.**

These services can usually be filed electronically unless they are covered by Medicare and the beneficiary was sixty-five (65) or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims so they may receive special handling.

252.482 Services Not Medicare Approved

11-1-26

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services not covered by Medicare but covered by Medicaid. These exceptions may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS

11-1-26

- A. Effective for dates of service on and after 6/1/2022, drug treatment is available to qualifying Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:
1. Pediatric acute-onset neuropsychiatric syndrome (PANS).
 2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).
- B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).
- C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:
1. The drug treatment must be authorized under a Treatment Plan; and
 2. The Treatment Plan must be established by the approved PANS/PANDAS provider.
- D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. **View or print contact information for the QIO.**
- E. The authorized procedure codes and required modifiers are found in the following link:

View or print the procedure codes for Physician Assistant services, including PANS and PANDAS procedure codes.

252.484 Injections, Therapeutic and/or Diagnostic Agents

11-1-26

Physician Assistants shall administer injections, therapeutic agents, and diagnostic agents according to the rules set forth in the **Medicaid Physician provider manual** and within the scope of practice guidelines.

View or print the procedure codes for Physician Assistant services.

SECTION II -PHYSICIAN ASSISTANT CONTENTS

TOC required

200.000 PHYSICIAN ASSISTANT GENERAL INFORMATION

201.000 **Arkansas Medicaid Requirements for Participation in the Physician Assistant Program** 11-1-26

The Arkansas Medicaid Program enrolls Physician Assistants for participation in the Physician Assistant Program. Physician Assistant Program providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The provider must be licensed by the state authority in the state in which services are furnished.
- B. The following documents must be submitted with the provider application and Medicaid contract:
 1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Section 201.300 of this manual.)
 2. Providers have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must inform the Medicaid Provider Enrollment Unit of his or her Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
 3. Providers who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.

201.001 **Electronic Signatures** 11-1-26

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

201.100 **Group Providers** 11-1-26

Group providers of Physician Assistant services must meet the following criteria to be eligible for participation in the Arkansas Medicaid Program. Since physician assistants must be supervised by a physician, there is not a physician assistant group provider type. However, physician assistants may affiliate with other group providers including physician groups, FQHCs, and RHCs.

If a Physician Assistant is a member of a group, each individual Physician Assistant and the group must both enroll according to the following criteria:

- A. Each individual Physician Assistant within the group must enroll following the criteria established in Section 201.000.
- B. All group providers are “pay to” providers only. The service must be performed and billed by a Medicaid-enrolled Physician Assistant within the group.

201.200 **Providers in Arkansas and Bordering States** 11-1-26

Providers in Arkansas and the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas) that satisfy Arkansas Medicaid participation requirements may be enrolled as **routine services providers**.

Routine services providers may furnish and claim reimbursement for services covered by Arkansas Medicaid, subject to benefit limitations and coverage restrictions set forth in this manual.

Services rendered by physician assistants in the six (6) border states must comply with the scope of practice and limitations in privileges specified in Arkansas Law. In addition, physician assistants are only allowed to perform services authorized by their supervising physicians. Their supervising physicians must also be actively enrolled as participating Arkansas Medicaid providers.

201.210 Providers in Non-Bordering States

11-1-26

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid.

To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the DMS website and submit the application, contract, and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View the provider enrollment application on the Health Care Provider Portal](#). [View or print Provider Enrollment Unit Contact information](#). In addition, the physician assistant's supervising physicians must be actively enrolled with Arkansas Medicaid.

- B. Limited services providers remain enrolled for one (1) year.
1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one (1) year past the most recent claim's last date of service, if the enrollment file is kept current.
 2. During the enrollment period, the provider may file any subsequent claims directly with the Medicaid fiscal agent.
 3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.300 Certification for Physician Assistant

11-1-26

The Physician Assistant must be licensed as a Physician Assistant by the state in which services are furnished.

202.000 Medical Records Physician Assistants are Required to Keep

11-1-26

- A. Physician Assistants are required to keep the following records and, upon request, furnish the records to authorized representatives of the Department of Human Services/Division of Medical Services, the Office of Medicaid Inspector General, the state Medicaid Fraud Control Unit and representatives of the Centers for Medicare and Medicaid Services (CMS) or the Department of Health and Human Services (DHHS) Office of Inspector General (OIG):
1. History and physical examinations;
 2. Chief complaint on each visit;
 3. Tests and results;

4. Diagnoses;
 5. Service or treatment, including prescriptions, or a referral to a physician for prescriptions, and record of physician referral or consultation;
 6. Signature or initials of the Physician Assistant after each visit;
 7. Copies of records pertinent to services delivered by the Physician Assistant and billed to Medicaid;
 8. Records must include the service date of each service billed to Medicaid.
- B. Patient records must support the levels of service billed to Medicaid, in accordance with the American Medical Association's Common Procedural Terminology (CPT) standards.
- C. All required records must be kept for a period of five (5) years from the ending date of service; or, until all audit questions, appeal hearings, investigations, or court cases are resolved, whichever period is longer.
- D. Furnishing patient medical records on request to authorized individuals and agencies listed above in part A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions. (See Section 142.300 for additional information regarding record keeping requirements).
- E. All documentation must be made available to representatives of the above authorized individuals and agencies during normal business hours at the time an audit is conducted. All documentation must be available at the provider's place of business. If an audit determines that recoupment is necessary, additional documentation will be accepted for thirty-five (35) days after the date of the recoupment letter. Additional documentation will not be accepted later.

203.000 **The Physician Assistant's Role in Home Health Services**

11-1-26

Physician Assistants must meet the home health rules and regulations found in [Section II of the Medicaid Home Health Provider Manual](#).

203.100 **The Physician Assistant's Role in the Pharmacy Program**

11-1-26

Except for drugs in the categories excluded from coverage, Arkansas Medicaid covers all drug products manufactured by companies with listed labeler codes.

A Physician Assistant with prescriptive authority (verified by the Certificate of Prescriptive Authority Number issued by the licensing authority of the state in which services are furnished) may only prescribe legend drugs and controlled substances identified in the state licensing rules and regulations. Medicaid reimbursement will be limited to prescriptions for drugs in these schedules.

A Physician Assistant who prescribes medication to an Arkansas Medicaid Beneficiary must do so in accordance with [Section II of the Arkansas Medicaid Pharmacy Provider Manual](#).

Prescribers must obtain the latest information regarding prescription drug coverage at the website listed in the contact information for DHS or its designated Pharmacy Vendor. [View or print contact information for the DHS designated Pharmacy Vendor.](#)

203.200 **The Physician Assistant's Role in the Child Health Services (EPSDT) Program**

11-1-26

The Child Health Services (EPSDT) program is a federally mandated child health component of Medicaid. It is designed to bring comprehensive health care to individuals eligible for medical assistance from birth until their twenty-first (21st) birthday. The purpose of this program is to detect and treat health problems in the early stages and to provide preventive health care,

including necessary immunizations. Child Health Services (EPSDT) combines case management and support services with periodic screening, as well as diagnostic and treatment services delivered.

Physician Assistants who choose to enroll as PCPs must follow the rules set forth in the [Child Health Services \(EPSDT\) provider manual](#).

203.300 The Physician Assistant's Role in the ARKids First-B Program

11-1-26

The ARKids First-B Program, established by Arkansas Act 407 of 1997, extends health care coverage to Arkansas' uninsured children. The health care delivery network for ARKids First-B Program is ConnectCare. ConnectCare is the Primary Care Case Management (PCCM) Program utilized by the Arkansas Medicaid Program.

Preventive health screens are covered in the ARKids First-B Program for ARKids First-B eligible children from birth through eighteen (18) years of age. Preventive health screens are like EPSDT screens. Except for routine newborn care, preventive health screens must be performed by the primary care physician (PCP) or referred by the PCP to an appropriate provider for screening. If a Physician Assistant receives a referral from the child's PCP for a screen and a problem is discovered, treatment may be provided with consultation from the PCP.

Physician Assistants enrolled as a Medicaid provider and interested in participating in the ARKids First-B program can [download the ARKids First-B manual](#) for further information.

203.400 Physician Assistant's Role in Early Intervention Reporting for Children from Birth to Three Years of Age

11-1-26

Part C of the Individuals with Disabilities Education Act (IDEA '97) mandates the provision of early intervention services to infants and toddlers, ages birth to thirty-six (36) months of age. Health care providers, including Physician Assistants, offering any early intervention services to an eligible child must refer the child to the Division of Developmental Disabilities Services for possible enrollment in First Connections, the Part C Early Intervention Program in Arkansas. Federal regulations at 34 CFR 303.321.d.2.ii require health care professionals to refer potentially eligible children within two (2) days of identifying them as candidates for early intervention.

- A. A child must be referred if he or she is age birth to three (3) years and meets one or more of the following criteria:
1. Developmental delay – a delay of twenty-five percent (25%) or greater in one (1) of the following areas of development:
 - a. Physical (gross/fine motor).
 - b. Cognitive.
 - c. Communication.
 - d. Social or emotional.
 - e. Adaptive and self-help skills.
 2. Diagnosed physical or mental condition – examples of such conditions include but are not limited to:
 - a. Down's Syndrome and chromosomal abnormalities associated with mental condition.
 - b. Congenital syndromes associated with delays such as Fetal Alcohol Syndrome, intra-uterine drug exposure, prenatal rubella, severe microcephaly, and macrocephaly.
 - c. Maternal Acquired Immune Deficiency Syndrome (AIDS).
 - d. Sensory impairments such as visual or hearing disorders.

- B. The Division of Developmental Disabilities Services (DDS) within the Department of Human Services is the lead agency for early intervention as required in Part C of IDEA in Arkansas. Referrals to First Connections may be made either through the DDS Service Coordinator for the child's county of residence or directly to a DDS licensed community program.

203.500 The Physician Assistant's Role in Family Planning Services

11-1-26

Arkansas Medicaid encourages reproductive health and family planning by covering a comprehensive range of family planning services provided by Physician Assistants and other providers. Medicaid beneficiaries' family planning services are in addition to their other medical benefits. Family planning services do not require PCP referral.

- A. Refer to Sections 214.321 through 214.333 of this manual for family planning coverage information.
- B. Refer to Sections 252.430 and 252.431 of this manual for family planning services special billing instructions and procedure codes.

203.600 The Physician Assistant's Role in Hospital Services

11-1-26

- A. Medicaid covers medically necessary hospital services, within the constraints of the Medicaid Utilization Management Program (MUMP) and applicable benefit limitations. (Refer to Section 214.711.)
- B. The care and treatment of a patient must be under the direction of a licensed physician, a licensed Physician Assistant, a certified nurse-midwife, a nurse practitioner, or a dentist with hospital staff privileges.
- C. DHS or its designated vendor reviews all inpatient hospital transfers, and all inpatient stays longer than seven (7) days for the Medicaid Utilization Management Program (MUMP).

DHS or its designated vendor also completes post-payment reviews of hospital stays for medical necessity determinations. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.](#)

- D. Hospital claims are also subject to review by the Arkansas Medicaid Medical Director for the Medicaid Program.
 - 1. If Medicaid denies a hospital's claim for lack of medical necessity, payments to Physician Assistants for evaluation and management services incidental to the hospitalization are subject to recoupment by the Medicaid agency.
 - 2. Physician Assistants and hospitals may not bill a Medicaid beneficiary for a service Medicaid has denied due to not meeting medical necessity criteria.
 - 3. Physician Assistants and hospitals may not rebill inpatient services previously denied for lack of medical necessity as outpatient services.

203.700 Reserved

11-1-26

204.000 Role of Quality Improvement Organization (QIO)

11-1-26

The Quality Improvement Organization (QIO) reviews all federally and state funded hospital inpatient services. The purpose of such review is the promotion of effective, efficient, and economical delivery of health care services of proper quality and assurance that such services conform to appropriate professional standards. QIO reviews are mandated to ensure that federal

payment for services will take place only when they are determined to be medically necessary, consistent with professionally recognized health care standards and provided in the most appropriate setting and location.

A pattern of aberrant practice may result in a Physician Assistant being subject to pre-payment review of up to one hundred percent (100%) of admissions. After the appeal process, QIO forwards any denials to the state agency for recoupment of funds.

210.000 PROGRAM COVERAGE

211.000 Introduction 11-1-26

The Medical Assistance (Medicaid) Program is designed to assist eligible beneficiaries in obtaining medical care within the guidelines specified in [Section I](#) of this manual. All Medicaid benefits are based upon medical necessity. [See the Glossary of this manual](#) for “medical necessity” definition.

212.000 Physician Assistant 11-1-26

A Physician Assistant, as applicable to this program, is a licensed professional who meets the participation requirements and enrollment criteria for physician assistant as defined by the state licensing authority.

Physician Assistant services are services furnished according to Arkansas Code 17-105-101 and rules issued by the Arkansas State Medical Board. Physicians Assistants are dependent medical practitioners practicing under the supervision of the physician, for which the physician takes full responsibility.

Note: A physician assistant providing services during a surgical procedure is not covered as an assistant surgeon.

The Physician Assistant engages in collaborative decision-making about the health care needs of patients with the physician under which direct supervision is vested. Collaboration with health professionals and others occurs in making decisions about other health care needs. The Physician Assistant plans and initiates health care programs as a member of the health care team. The supervising physician is directly accountable and responsible for the quality of care provided.

213.000 Scope 11-1-26

The scope of the Physician Assistant Program includes Medicaid covered services provided by pediatrics, family, obstetric-gynecologic (women’s health care), and gerontological Physician Assistants in accordance with state and federal regulations.

Services provided through the Physician Assistant Program include:

- A. Assessment and diagnostic services
- B. Development and implementation of treatment plans
- C. Evaluation of beneficiary outcomes
- D. Referrals to appropriate providers when the health status of the beneficiary requires additional diagnostic and treatment services
- E. Other services as authorized by the supervising physician or services as defined in the physician assistant’s delegation agreement with the supervising physician

214.000 Coverage**11-1-26**

Many Physician Assistant services covered by the Arkansas Medicaid Program have coverage restrictions or are benefit limited. Coverage restrictions are the circumstances under which certain services will be covered. Benefit limits are the limits on the quantity of covered services beneficiaries may receive. Benefit limits for some services may be extended if medically necessary. See Sections 214.000 through 214.800 for information about covered Physician Assistant services with restrictions, benefit limits, or both.

214.100 Exclusions**11-1-26**

Exclusions are those services not covered in the Medicaid Physician Assistant Program and any covered services furnished by a Physician Assistant that are not within their scope of practice as defined by the state licensing authority. Services are not covered when provided by an employed or contracted Physician Assistant who is not enrolled in the Physician Assistant Program.

Medicaid does not cover services that are not medically necessary or are not generally accepted by the medical profession. Medicaid does not cover services that are not properly documented by diagnoses that certify medical necessity.

214.200 General Physician Assistant Services**11-1-26**

- A. Services provided by a Physician Assistant include initial visits and established patient visits for:
 - 1. Diagnosis and evaluation.
 - 2. Treatment services.
 - 3. Health management services for prevention and early intervention.
 - 4. Appropriate referrals to other health care providers for diagnostic and treatment services.
- B. Some services (for example: pelvic exams, prostate massages, and removal of sutures) are not considered a separate service from an office visit.

214.210 Physician Assistant Services Benefit Limits**11-1-26**

- A. For clients twenty-one (21) years of age or older, PA services provided in a physician office, a PA office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

- 1. PA services in the office, patient's home, or nursing facility;
- 2. Physician services in the office, patient's home or nursing facility;
- 3. Rural health clinic (RHC) encounters;
- 4. Medical services furnished by a dentist;
- 5. Medical services furnished by an optometrist;
- 6. Certified nurse-midwife services;
- 7. Federally qualified health center (FQHC) encounters;
- 8. APRN services in the office, patient's home, or nursing facility; and
- 9. Clinical Nurse Specialist services.

The established benefit limit does not apply to beneficiaries under twenty-one (21) years of age.

Obstetric office visits are not counted in the limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 214.900 of this manual for procedures for obtaining extension of benefits.

214.300 Reserved 11-1-26

214.310 Reserved 11-1-26

214.320 Reserved 11-1-26

214.321 Family Planning Services for Women in Aid Category 61, PW 11-1-26

Women in Aid Category 61, Pregnant Women (PW), are eligible for all Medicaid-covered family planning services through the last day of the month in which the sixtieth (60th) day postpartum falls.

Aid Category 61 PW Unborn Child does not include family planning benefits.

214.330 Family Planning Coverage Information 11-1-26

- A. Medicaid encourages reproductive health and family planning by reimbursing Physician Assistants for a comprehensive range of family planning services.
 1. Family planning services do not require a PCP referral.
 2. Medicaid beneficiaries receive family planning services benefits in addition to their other medical benefits, when providers bill the services specifically as family planning services.
 3. Family planning prescriptions are unlimited and do not count toward the benefit limit.
 4. Extension of benefits is not available for family planning services.
 5. Abortion is not a family planning service in the Medicaid Program.
- B. Other than full coverage aid categories, Medicaid covers one (1) basic family planning examination and three (3) periodic family planning visits per beneficiary, per state fiscal year (July 1 through June 30). Refer to Sections 214.321 through 214.333 of this manual for service description and coverage information.
- C. Physician Assistants participating in the Medicaid Family Planning Services Program provide the services listed in Sections 214.321 through 241.333 to beneficiaries of childbearing age.
- D. Physician Assistants who do not want to provide family planning services may refer their patients to other providers. DHS County Offices maintain local and area qualified family planning provider lists. Listed providers include:
 1. Local Department of Health units;
 2. Obstetricians and gynecologists;
 3. Physicians;
 4. Rural Health Clinics;
 5. Federally Qualified Health Centers;
 6. Family planning clinics;

7. Physicians; and
 8. Certified Nurse-Midwives.
- E. Complete billing instructions for family planning services are in Sections 252.430 through 252.431 of this manual.

214.331 Physician Assistant Basic Family Planning Visit**11-1-26**

Medicaid covers one (1) basic family planning visit per beneficiary per state fiscal year (July 1 through June 30). The basic visit comprises the following:

- A. Medical history and medical examination, including head, neck, breast, chest, pelvis, abdomen, extremities, weight, and blood pressure.
- B. Counseling and education regarding:
 1. Breast self-exam.
 2. The full range of contraceptive methods available.
 3. HIV and STD prevention.
- C. Prescription for any contraceptives selected by the beneficiary.
- D. Laboratory services, including, as necessary:
 1. Pregnancy test.
 2. Hemoglobin and hematocrit.
 3. Sickle cell screening.
 4. Urinalysis testing for albumin and glucose.
 5. Papanicolaou (PAP) smears for cervical cancer.
 6. Testing for sexually transmitted infections.

214.332 Physician Assistant Periodic Family Planning Visit**11-1-26**

Medicaid covers three (3) periodic family planning visits per beneficiary per state fiscal year (July 1 through June 30). The periodic visit includes follow-up medical history, weight, blood pressure, and counseling regarding contraceptives and possible complications of contraceptives. The purpose of the periodic visit is to evaluate the patient's contraceptive program, renew or change the contraceptive prescription and to provide the patient with additional opportunities for counseling regarding reproductive health and family planning.

214.333 Contraception**11-1-26**

- A. Prescription and Non-Prescription Contraceptives:
 1. Medicaid covers birth control pills and other prescription contraceptives as a family planning prescription benefit.
 2. Medicaid covers non-prescription contraceptives as a family planning benefit when a physician or other licensed practitioner with prescriptive authority writes a prescription for them.
- B. Contraceptive Implant Systems:
 1. Medicaid covers the contraceptive implant systems, including implants and supplies.
 2. Medicaid covers insertion, removal, and removal with reinsertion.
- C. Intrauterine Device (IUD):

1. Medicaid pays for IUDs as a family planning benefit.
 2. Medicaid reimburses physicians that supply the IUD at the time of insertion.
 3. Medicaid pays physicians for IUD insertion and removal.
- D. Medroxyprogesterone Acetate:
- Medicaid covers medroxyprogesterone acetate injections for birth control.
- E. Sterilization:
1. All adult (twenty-one (21) years of age or older) male or female Medicaid beneficiaries who are mentally competent are eligible for sterilization procedures as long as they remain Medicaid-eligible.
 2. Refer to Sections 252.430 through 252.431 of this manual for procedure codes and billing instructions for family planning services.

214.400 **Reserved** **11-1-26**

214.500 **Laboratory and X-Ray Services Referral Requirements** **11-1-26**

A Physician Assistant referring a Medicaid beneficiary for laboratory, radiology or machine testing services must specify an ICD diagnosis code for each test ordered, *and include in the order*, pertinent supplemental diagnosis supporting the need for the test(s).

- A. Diagnostic facilities, hospital labs, and outpatient departments performing reference diagnostics rely on the referring Physician Assistant to establish medical necessity.
- B. The diagnoses provide documentation of medical necessity to the reference diagnostic facilities performing the tests.
- C. Physician Assistants must follow the Centers for Medicare and Medicaid Services (CMS) requirements for medical claim diagnosis coding when submitting diagnosis coding with their orders for diagnostic tests.
- D. The Medicaid agency will enforce the CMS requirements for diagnosis coding, as those requirements are set forth in the ICD volume concurrent with the referral dates and the claim dates of service.
- E. The following ICD diagnosis codes may not be utilized ([View ICD Codes](#)).

Medicaid regulations regarding collection, handling, and conveyance of specimens are as follows:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in circumstances including:
 - 1 drawing a blood sample through venipuncture (for example: inserting into a vein a needle with syringe or vacutainer to draw the specimen); or,
 - 2 collecting a urine sample by catheterization.

The following procedure codes should be used when billing for specimen collection:

[View or print the procedure codes for Physician Assistant services.](#)

NOTE: The P codes listed within the procedure codes hyperlink are the Urinary Collection Codes.

Reimbursement for laboratory procedures requiring a venous blood specimen includes the collection fee when performed by the same provider. If laboratory procedures requiring a venous blood specimen are performed in the office and other laboratory procedures are sent to a reference laboratory on the same date of service, a collection fee may not be billed.

Independent laboratories must meet the requirements to participate in Medicare. Independent laboratories may only be paid for laboratory tests they are certified to perform. Laboratory services rendered in a specialty for which an independent laboratory is not certified are not covered and claims for payment of benefits for these services will be denied.

214.510 Diagnostic Laboratory and Radiology/Other Services Benefit Limits 11-1-26

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting.

Please refer to Section 229.100 through 229.130 of the [Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual](#) for information about requesting extension of benefits.

All the benefit limits in this section are calculated per State Fiscal Year (SFY: July 1 through June 30).

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 (2) new annual caps.

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

214.600 Obstetrical Services 11-1-26

The Medicaid Program covers obstetrical services for Medicaid-eligible clients in *full* coverage aid categories with a medically verified pregnancy.

Aid category 61, PW beneficiaries are eligible for full range Medicaid coverage. Aid category 61, PW pregnant women's eligibility ends on the last day of the month in which the sixtieth (60th) postpartum day falls.

214.610 Covered Physician Assistant Obstetrical Services 11-1-26

Covered Physician Assistant obstetrical services may be provided when medically necessary. These services are *limited* to antepartum and postpartum care. Appropriate referrals must be made to a physician or a certified nurse-midwife for complete obstetrical services to include delivery.

214.620 Risk Management Services for High-Risk Pregnancy 11-1-26

The Physician Assistant may provide risk management services authorized under the agreement with their supervising physician. If a Physician Assistant does not choose to provide high-risk pregnancy services but believes the patient would benefit from such services, he or she may refer the patient to a clinic that offers the services.

Covered risk management services described in parts A through E below are considered as one (1) service with a benefit limit of thirty-two (32) cumulative units. The early discharge home visit described in part F is considered as a separate service.

A. Risk Assessment

Risk assessment is defined as a medical, nutritional, and psychosocial assessment by a Physician Assistant or a registered nurse on the Physician's staff, to designate patients as high or low risk.

1. Medical assessment, using the Hollister Maternal and Newborn Record System or equivalent form includes:
 - a. Medical history,
 - b. Menstrual history, and
 - c. Pregnancy history.
2. Nutritional assessment includes:
 - a. 24-hour diet recall,
 - b. Screening for anemia, and
 - c. Weight history.
3. Psychosocial assessment includes criteria for an identification of psychosocial problems that may adversely affect the patient's health status.

Maximum: Two (2) units per pregnancy

B. Case Management Services

Case management services are provided by a Physician Assistant, APRN, Clinical Nurse Specialist, licensed social worker, or registered nurse to assist pregnant women eligible under Medicaid in gaining access to needed medical, social, educational, and other services (such as locating a source of services, making an appointment for services, arranging transportation, arranging hospital admission, locating a physician to deliver a newborn, following up to verify that the patient kept her appointment, and rescheduling the appointment if needed).

Maximum: One (1) unit per month. A minimum of two (2) contacts per month must be provided. The case management contact may be with the patient, other professionals, family, or other caregivers.

C. Perinatal Education

Educational classes provided by a health professional (physician, physician assistant, APRN, Clinical Nurse Specialist, public health nurse, nutritionist, or health educator) include:

1. Pregnancy;
2. Labor and delivery;
3. Reproductive health;
4. Postpartum care;
5. Nutrition in pregnancy; and
6. Maximum: Six (6) classes (units) per pregnancy.

D. Nutrition Consultation — Individual

Nutrition consultation services provided for high-risk pregnant women by a registered dietitian or a nutritionist eligible for registration by the Commission on Dietetic Registration must include at least one (1) of the following:

1. An evaluation to determine health risks due to nutritional factors and development of a nutritional care plan; and
2. Nutritional care plan follow-up and reassessment as indicated.

Maximum: Nine (9) units per pregnancy

E. Social Work Consultation

Services provided for high-risk pregnant women by a licensed social worker must include at least one (1) of the following:

1. An evaluation to determine health risks due to psychosocial factors and development of a social work care plan
2. Social work plan follow-up, appropriate intervention, and referrals

Maximum: Six (6) units per pregnancy

F. Early Discharge Home Visit

If a physician or certified nurse-midwife chooses to discharge a low-risk mother and newborn from the hospital early (less than twenty-four (24) hours after delivery), the physician or certified nurse-midwife may provide a home visit to the mother and baby within seventy-two (72) hours of the hospital discharge. The physician or certified nurse-midwife may request an early discharge home visit from any clinic that provides perinatal services. Visits will be made by the physician or certified nurse-midwife's order (includes a hospital discharge order).

A home visit may be ordered for the mother and infant discharged later than twenty-four (24) hours when there is specific medical reason for home follow-up.

Billing instructions and procedure codes may be found in [Section 252.450](#).

214.700 **Reserved** **11-1-26**

214.710 **Inpatient Services** **11-1-26**

Physician Assistant inpatient services must meet the Medicaid requirement of medical necessity. The Quality Improvement Organization (QIO) will deny payments for inpatient admissions and subsequent inpatient services when they determine that inpatient care was not necessary.

Inpatient services are subject to QIO review for medical necessity whether the Physician Assistant's supervising physician admitted the patient, or whether Medicaid deemed the inpatient status criteria in Section 214.711.

The attending physician must document the medical necessity of admitting a patient to observation status, whether the patient's condition is emergent or non-emergent. Physician Assistant and hospital claims for hospital observation services are subject to post-payment review to verify medical necessity.

All medical staff must provide inpatient service in compliance with Section 6 of the [Arkansas State Board of Health Rules for Hospitals and Related Institutions in Arkansas](#).

214.711 **Medicaid Utilization Management Program (MUMP)** **11-1-26**

The Medicaid Utilization Management Program (MUMP) determines covered lengths of stay in inpatient acute care and general hospitals, in state and out of state.

Length-of-stay determinations are made by the Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program.

Individuals in all Medicaid eligibility categories and all age groups, except beneficiaries under one (1) year of age, are subject to this policy. Medicaid beneficiaries under one (1) year of age at the time of admission are exempt from the MUMP policy for dates of service before their first

birthday. Refer to item “E” below for the procedure to follow when a child’s first birthday occurs during an inpatient stay.

The procedures for the MUMP are as follows:

- A. Medicaid will reimburse hospitals for up to seven (7) days of inpatient service with no pre-certification requirement, except for admissions by transfer from another hospital.
- B. If the attending Physician Assistant’s supervising physician determines the patient should not be discharged by the eighth (8th) day of hospitalization, a hospital medical staff member may contact DHS or its designated vendor and request an extension of inpatient days.

[View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of inpatient stays.](#)

- C. The number of days allowed for an extension will be based on medical judgment utilizing Medicaid guidelines.
- D. When a Medicaid beneficiary reaches one (1) year of age during an inpatient stay, the days from the admission date through the day before the patient’s birthday are exempt from the MUMP policy. MUMP policy becomes effective on the one-year birthday. The patient’s birthday is the first day of the seven (7) days not requiring MUMP certification. If the stay continues beyond the seventh (7th) day (inclusive) of the patient’s first birthday, hospital staff must apply for MUMP certification of the additional days.
- E. Additional extensions may be requested as needed.
- F. Reconsideration reviews of denied extensions may be requested by sending the medical record to the [QIO contractor](#) through regular mail or expedited by overnight express. The hospital will be notified by the next working day.
- G. Calls to extend days may be made at any point from the seventh (7th) day of stay through discharge. However, the provider must accept financial liability should the stay not meet the necessary medical criteria for inpatient services. If the provider chooses to delay calling for extension verification and the services are denied based on medical necessity, the beneficiary may not be held liable. All calls will be limited to ten (10) minutes to allow equal access to all providers.
- H. Inpatient stays for bone marrow, liver, heart, lung, skin, and pancreas and kidney transplant procedures are excluded from this review program.
- I. A retrospective or post-payment random sample review will be conducted for all admissions, including inpatient stays of seven (7) days or less, to ensure that medical necessity for the services is substantiated.
- J. Admissions of retroactive eligible beneficiary: If eligibility is identified while the patient is still inpatient, the hospital may request retrospective review of those days already used past the original seven (7) for a determination of post-authorization and concurrent evaluation of future extended days.

If the retroactive eligible beneficiary is not identified until after discharge, and the hospital files a claim and receives a denial for any days past the original seven (7) allowed, the hospital may request post-extension evaluation approval of the denied days. If granted, the claim may be refilled. If the length of stay is more than thirty (30) days, the provider shall submit the entire medical record to DHS or its designated vendor for review.

- K. Claims submitted without extension will result in automatic denials of any days billed beyond the seventh (7th) day. The only exceptions are for claims reflecting third party liability and patients with retroactive Medicaid eligibility described in items G and J above.

- L. If a patient is transferred from one (1) facility to another, the receiving facility must contact DHS or its designated vendor within twenty-four (24) hours of admitting the patient to qualify the inpatient stay. If an admission falls on a weekend or holiday, the provider may contact DHS or its designated vendor on the first working day following the weekend or holiday.
- M. The certification process for extensions of inpatient days described in this section is a separate requirement from the prior authorization process. If a procedure requires prior authorization, the provider must request and receive prior authorization for the procedure code to be reimbursed.
- N. If a provider fails to contact DHS or its designated vendor for an extension of inpatient days because the beneficiary has private insurance or Medicare Part A and later receives a denial due to non-covered service, lost eligibility, benefits exhausted, or similar, then post-certification of days past the original seven (7) days may be obtained by the following procedures:
 - 1. Send a copy of the denial notice received from the third-party payer to DHS or its designated vendor.
 - 2. Include a note requesting post-certification, the full name of the requester, and a phone number where the requester may be reached.Upon receipt of the denial copy and the provider request, a coordinator will call the provider to obtain certification information.
- O. If a third-party insurer pays for an approved number of days, Medicaid will not grant an extension for days beyond the number of days approved by the private insurer.

214.712 Evaluation and Management**11-1-26**

- A. Medicaid covers Physician Assistant evaluation and management services for hospital inpatients on Medicaid-covered inpatient days only. The single exception to this policy is that Medicaid will cover discharge day management. Medicaid does not remit the hospitals per diem for the day of discharge unless it is also the admission day. Medicaid reimburses Physician Assistants for medically necessary discharge day management unless the Physician Assistant evaluation and management services for that day are included in another service, or unless the Physician Assistant does not customarily bill private-pay patients for discharge day management.
- B. The Medicaid Program covers only one (1) evaluation and management service per day, regardless of how many times the Physician Assistant sees the patient.
- C. The Medicaid Program will recover payments to Physician Assistants for inpatient evaluation and management services on days when the hospital's inpatient claims are denied (or would be denied, if filed) for:
 - 1. Exceeding benefit limits;
 - 2. Failure to pre-certify inpatient days, when applicable; or
 - 3. Lack of medical necessity.

214.713 Professional Components of Diagnostic and Therapeutic Procedures**11-1-26**

Hospital reimbursement for inpatient services covered by Medicaid includes the non-professional components (technical components) such as machine tests, laboratory tests, and radiology procedures provided to inpatients.

Reimbursement to Physician Assistants and independent laboratories for laboratory and radiology services for inpatients is solely for the professional component of machine tests, radiology services, and anatomical laboratory services.

Medicaid does not pay for technical components of diagnostic procedures (or complete procedures that include a technical component) or for clinical laboratory procedures performed for diagnosing and treating an inpatient hospital beneficiary. Hospitals must furnish or purchase those ancillary services.

214.714 Inpatient Hospital Benefit Limits 11-1-26

- A. An annual benefit limit of twenty-four (24) medically necessary days per state fiscal year (July 1 through June 30) applies for Medicaid beneficiaries twenty-one (21) years of age and older. Upon the twenty-fifth day, any medically necessary inpatient days will be covered at a lower rate of four hundred dollars (\$400) per day.
- B. Inpatient hospital benefit limits do not apply for beneficiaries under twenty-one (21) years of age in the Child Health Services (EPSDT) Program.

214.720 Outpatient Hospital Services 11-1-26

Outpatient hospital Physician Assistant services are divided into two (2) types of service for the purpose of coverage and reimbursement determination.

214.721 Emergency Services 11-1-26

Physician Assistant outpatient hospital visits are covered as an emergency when the beneficiary's medical condition constitutes an emergency medical condition. ([Refer to the Glossary of this manual](#) for the definition of emergency services.)

Services not considered as emergency services are covered with primary care physician approval, or the beneficiary may be billed for the services.

214.722 Non-Emergency Services 11-1-26

Coverage of non-emergency Physician Assistant services in an outpatient hospital setting is restricted to a visit charge and the professional component for machine tests, radiology, and anatomical laboratory procedures.

214.800 Occupational, Physical, and Speech-Language Therapy 11-1-26

Medicaid covers occupational, physical, and speech-language therapy services for eligible beneficiaries. Please refer to the [Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services manual](#).

214.900 Procedures for Obtaining Extension of Benefits 11-1-26

214.910 Extension of Benefits for Diagnostic Laboratory and Radiology/Other Services 11-1-26

The Medicaid Program's diagnostic laboratory services benefit limit and radiology/other services benefit limit each apply to the outpatient setting. Please refer to Section 229.100 through 229.130 of the [Physician/Independent Lab/CRNA/Radiation Therapy Center provider manual](#) for information about requesting extension of benefits.

214.940 Administrative Reconsiderations and Appeals 11-1-26

- 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.

214.950 **Reserved** **11-1-26**

214.952 **Continued Services During the Appeal Process** **11-1-26**

Services may be continued pending the outcome of an appeal in accordance with [Section 161.500 of this Manual](#).

215.000 **Fluoride Varnish Treatment** **11-1-26**

Medicaid covers fluoride varnish application, ADA code, performed by physicians who have completed the online training program approved by the Arkansas Department of Health, Office of Oral Health.

[View or print the procedure codes for Physician Assistant services.](#)

Eligible physicians may delegate the application to a nurse or other licensed health care professional under his or her supervision that has also completed the online training. The online training course can be accessed at <http://ar.train.org>. Each provider must maintain documentation to establish his or her successful completion of the training and submit a copy of the certificate of completion to Provider Enrollment.

220.000 **PRIOR AUTHORIZATION**

221.000 **Procedure for Obtaining Prior Authorization** **11-1-26**

- A. Certain medical and surgical procedures are not covered without prior authorization, because of federal requirements or because of the elective nature of the surgery.
- B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting extension of benefits.](#)
 - 1. Prior authorization determinations are in accordance with established medical or administrative criteria combined with the professional judgment of physician advisors.
 - 2. Payment for prior-authorized services is in accordance with federal regulations.
- C. Prior authorization of service does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided.

221.100 **Post-Procedural Authorization** **11-1-26**

Post-procedural authorization will be granted only for emergency procedures for beneficiaries twenty-one (21) years of age or older. Requests for post-authorization of an emergency procedure must be applied for on the first working day after the procedure is performed.

In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

221.110 Post-Procedural Authorization Process for Beneficiaries Under Age 21 11-1-26

- A. Providers performing surgical procedures that require prior authorization are allowed sixty (60) days from the date of service to obtain a prior authorization number if the beneficiary is under twenty-one (21) years of age.
- B. The following post-procedural authorization process must be followed when obtaining an authorization number.
 1. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.](#)
 2. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. [View or print contact information to obtain dates of eligibility.](#)
 3. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.
 4. Consultants are responsible for DHS or its designated vendor having their required and restricted procedures added to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

Providers must obtain prior authorization for procedures requiring authorization to prevent risk of denial due to lack of medical necessity.

221.200 Prescription Prior Authorization 11-1-26

Prescription drugs are available for reimbursement under the Medicaid Program when prescribed by a Physician Assistant with prescriptive authority. Certain prescription drugs may require prior authorization. The prescriber is responsible for requesting and obtaining the prior authorization. Information may be obtained from DHS or its designated vendor. [View or print contact information to obtain the DHS or designated vendor prescription drug information.](#)

The following information is available:

- A. Prescription drugs requiring prior authorization.
- B. Criteria for drugs requiring prior authorization.
- C. Forms to be completed for prior authorization.
- D. Procedures required of the prescriber to request and obtain prior authorization.

221.300 Procedures that Require Prior Authorization 11-1-26

Medical or surgical procedures that are generally restricted to the outpatient setting no longer require prior authorization for inpatient services.

230.000 REIMBURSEMENT

231.000 Method of Reimbursement 11-1-26

Medicaid reimbursement for Physician Assistant services is based on the lesser of the amount billed or the Title XIX maximum allowable.

231.010 Fee Schedules**11-1-26**

Medicaid provides fee schedules on the DMS website. [View the fee schedules](#). The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Medicaid before final payment is determined.

Procedure codes and fee schedules do not guarantee payment, coverage, or amount allowed. Information may be changed or updated at any time to correct a discrepancy or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Review Process**11-1-26**

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). [Refer to Section I, 110.400](#) of the manual to get instructions for requesting a review.

250.000 BILLING PROCEDURES**252.000 Introduction to Billing****11-1-26**

Physician Assistant providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

252.000 CMS-1500 Billing Procedures**252.100 Reserved****11-1-26****252.110 Billing Protocol for Computed Tomographic Colonography (CT)****11-1-26**

- A. The following procedure codes are covered for CT colonography for beneficiaries of all ages.

[View or print the procedure codes for Physician Assistant services.](#)

- B. Billing protocol for CT colonography procedure codes:

1. CT colonography is billable electronically or on paper claims.
2. For the Physician Assistant, the above listed procedure codes are only payable for the technical component.

See Section 252.442 for additional information about the technical component.

252.120 Reserved**11-1-26****252.130 Special Billing Instructions****11-1-26**

- A. Use the following procedure codes for billing.

[View or print the procedure codes for Physician Assistant services.](#)

- B. For consideration of any claims with payable CPT or HCPCS unlisted procedure codes, the provider must submit a paper claim that includes a description of the service that is being represented by that unlisted code on the claim form. Documentation that further describes the service provided must be attached and must include justification for medical necessity.
- C. If authorized by the supervising physician, a physician assistant shall be:
 - 1. Identified as the rendering provider in billing and claims processes when the physician assistant rendered the medical services to the Medicaid beneficiary; and
 - 2. Allowed to file claims as the billing provider for medical services provided to a Medicaid beneficiary by the physician assistant.

All other billing requirements must be met in order for payment to be approved.

252.131 Molecular Pathology

11-1-26

The following Molecular Pathology codes require prior authorization from DHS or its designated vendor. See Sections 221.000 through 221.300 for prior authorization procedures.

[View or print the procedure codes for Physician Assistant services.](#)

252.132 Special Billing Requirements for Lab and X-Ray Services

11-1-26

For consideration of payable unlisted CPT/HCPCS drug procedure codes:

- A. The provider must submit a paper claim that includes a description of the drug being represented by the unlisted procedure code.
- B. Documentation that further describes the drug provided must be attached and must include justification for medical necessity.
- C. **All other billing requirements must be met for payment to be approved.**

[View or print the procedure codes for Physician Assistant services.](#)

252.200 Reserved

11-1-26

252.210 National Place of Service (POS) Codes

11-1-26

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Inpatient Hospital	21
Off-Campus Outpatient Hospital	19
On-Campus Outpatient Hospital	22
Office	11
Patient's Home	12
Mobile Unit	15
Nursing Facility	32
Skilled Nursing Facility	31
Ambulance	41

Place of Service	POS Codes
Other Locations	99
Telehealth	02
Telehealth in Patient's Home	10

252.300 Billing Instructions – Paper Claims Only

11-1-26

Bill Medicaid for Physician Assistant services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if required information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form

11-1-26

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message, contact, or emergency telephone.

Field Name and Number	Instructions for Completion
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)	Required if insured's address is different from the patient's address.
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy or group number of the insured individual.
b. RESERVED SEX	Reserved for NUCC use. Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH SEX	Not required. Not required.

Field Name and Number	Instructions for Completion
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one (1) box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Name and title of referral source, whether an individual (such as a PCP) or a clinic or other facility.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.

Field Name and Number	Instructions for Completion
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving or billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	Identifies additional information about the beneficiary's condition or the claim. Enter the appropriate qualifiers describing the identifier. See www.nucc.org for qualifiers.
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate version of the International Classification of Diseases. List no more than 12 ICD diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not and will not adjust, void, or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one (1) charge on one (1) line), bill only for services provided within a single calendar month. 2. Some providers may bill on the same claim detail for two (2) or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Enter the appropriate place of service code. See Section 252.200 for codes.
C. EMG	Check "Yes" or leave blank if "No." EMG identifies if the service was an emergency.

Field Name and Number	Instructions for Completion
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 252.100 through 252.132.
MODIFIER	Modifier(s) if applicable.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening or referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to sixteen (16) numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid or ARKids First-B co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures

252.410 Clinic or Group Billing

11-1-26

Providers who wish to have payment made to a group practice or clinic must enroll as a group practice. When billing, enter the Clinic/Group pay-to Provider Identification Number in Field 33 after "GRP#." Enter the performing provider identification number in Field 24K. If more than one (1) Physician Assistant in a group practice provides services for a beneficiary, the clinic may bill for all their services on the same claim limited only by the size of the claim format.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

[View or print the procedure codes for Physician Assistant services.](#)

252.420 Evaluations and Management

252.421 Initial Visit

11-1-26

The American Medical Association's *Current Procedures Terminology* (CPT) codes should be used only for the first visit of a new patient. Each subsequent visit should be billed using an established patient code. A distinction is made in CPT codes for new or established patients for office visits, home visits, nursing facility visits and emergency room visits. Refer to the latest edition of the CPT for detailed information.

Providers are allowed to bill one (1) new patient visit procedure code per beneficiary, per attending provider in a three (3) year period.

252.422 Detention Time (Standby Service)

11-1-26

[View or print the procedure codes for Physician Assistant services.](#)

Procedure code must be used by Physician Assistants when billing for detention time.

One (1) unit equals thirty (30) minutes. A maximum of one (1) unit per date of service may be billed.

Procedure code is payable when provided in the inpatient hospital setting by a Physician Assistant.

252.423 Inpatient Hospital Visits 11-1-26

Each Physician Assistant is limited to billing one (1) day of care for each inpatient hospital covered day, regardless of the number of hospital visits rendered.

252.424 Hospital Discharge Day Management 11-1-26

[View or print the procedure codes for Physician Assistant services.](#)

Procedure code, hospital discharge day management, may not be billed by providers on the same date of service as an initial or subsequent hospital care code, procedures. Initial hospital care codes and subsequent hospital care codes may not be billed on the day of discharge.

252.425 Nursing Home Visits 11-1-26

The appropriate CPT procedure codes should be used when billing for Physician Assistant visits in a nursing facility.

252.426 Specimen Collections 11-1-26

The policy regarding collection, handling, and conveyance of specimens is:

- A. Reimbursement will not be made for specimen handling fees.
- B. A specimen collection fee may be allowed only in circumstances including:
 - 1 drawing a blood sample through venipuncture (for example, inserting into a vein a needle with syringe or vacutainer to draw the specimen); or
 - 2 collecting a urine sample by catheterization.

The following codes should be used when billing for specimen collection:

[View or print the procedure codes for Physician Assistant services.](#)

252.428 Services Not Considered a Separate Service from an Office Visit 11-1-26

Some services (examples include, but are not limited to, pelvic examinations, prostate massages, and removal of sutures) are not considered a separate service from an office visit. The charge for such services should be included in the office visit charge. Billing should be under the office visit procedure code that reflects the appropriate level of care. Procedure code should never be used for billing routine pelvic examinations, but should be used only when a pelvic examination is done under general anesthesia.

[View or print the procedure codes for Physician Assistant services.](#)

252.429 Health Examinations for ARKids First-B Beneficiaries and Medicaid Beneficiaries Under Age 21 11-1-26

Providers should refer to the Child Health Services (EPSDT) Provider manual and the ARKids First-B Provider manual for covered services and billing procedures.

252.430 Family Planning Services Program Procedure Codes**11-1-26**

- A. Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. **All procedure codes in these tables require a primary diagnosis code of family planning in each claim detail. Please note: See the tables below within this section to determine restrictions applicable to some procedures.** Laboratory procedure codes covered for family planning are listed in [Section 252.431](#).

- B. Sterilization

A copy of the properly completed Sterilization Consent Form (DMS-615), with all items legible, must be attached to each sterilization claim submitted from each provider before payment may be approved. Providers include hospitals, physicians, anesthesiologists, and assistant surgeons. It is the responsibility of the physician performing the sterilization procedure to distribute correct legible copies of the signed consent form (DMS-615) to the hospital, anesthesiologist, and assistant surgeon.

Though prior authorization is not required, an improperly completed Sterilization Consent Form (DMS-615) results in the delay or denial of payment for the sterilization procedures. The checklist lists the items on the consent form that are reviewed before payment is made for any sterilization procedure. Use this checklist before submitting any consent form and a claim for payment to be sure that all criteria have been met. [View or print form DMS-615 \(English\) and the checklist. View or print form DMS-615 \(Spanish\) and the checklist.](#)

- C. The procedure code table located within the hyperlink below explains the family planning visit services payable to Physician Assistants.

NOTE: The procedure codes with the modifiers indicated in the table denote the Arkansas Medicaid description.

[View or print the procedure codes for Physician Assistant services.](#)

- D. The procedure code table explains family planning codes payable to Physician Assistants. Use the FP modifier for family planning services.

252.431 Family Planning Laboratory Procedure Codes**11-1-26**

Family planning services are covered for beneficiaries in full coverage aid categories. For information regarding additional aid categories, see Section 124.000. For eligible beneficiaries, these codes are payable when used for purposes other than family planning. Claims require modifier FP when the service diagnosis indicates family planning.

- A. The procedure code table within the hyperlink contains family planning laboratory procedure codes.*

[View or print the procedure codes for Physician Assistant services.](#)

*Procedure codes are limited to one (1) unit per beneficiary per state fiscal year; are payable only to pathologists and independent labs; require FP modifier only.

- B. Laboratory codes payable to [non-hospital-based Physician Assistants](#).

The procedure code table contains laboratory services payable to non-hospital-based Physician Assistants.

- C. Laboratory codes payable to [hospital-based Physician Assistants](#).

The procedure code table within the hyperlink describes the [laboratory services payable to hospital-based Physician Assistants](#).

252.438 National Drug Codes (NDCs)

11-1-26

Effective for claims with dates of service on or after January 1, 2008, Arkansas Medicaid implemented billing protocol per the Federal Deficit Reduction Act of 2005. This explains policy and billing protocol for providers that submit claims for drug HCPCS/CPT codes with dates of service on and after January 1, 2008.

The Federal Deficit Reduction Act of 2005 mandates that Arkansas Medicaid require the submission of National Drug Codes (NDCs) on claims submitted with *Healthcare Common Procedure Coding System, Level II/Current Procedural Terminology, 4th edition (HCPCS/CPT)* codes for **drugs** administered. The purpose of this requirement is to assure that the State Medicaid Agencies obtain a rebate from those manufacturers who have signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS).

A. Covered Labelers

Medicaid, by statute, will only pay for a drug procedure billed with an NDC when the pharmaceutical labeler of that drug is a covered labeler with Centers for Medicare and Medicaid Services (CMS). A “covered labeler” is a pharmaceutical manufacturer that has entered into a federal rebate agreement with CMS to provide each state a rebate for products reimbursed by Medicaid Programs. A covered labeler is identified by the first five (5) digits of the NDC. To assure a product is payable for administration to a Medicaid beneficiary, compare the labeler code (the first five (5) digits of the NDC) to the list of covered labelers which is maintained on the [DHS contracted Pharmacy vendor](#) website.

A complete listing of “**Covered Labelers**” is located on the website. See Diagram 1 for an example of this screen. The effective date is when a manufacturer entered into a rebate agreement with CMS. The *Labeler termination date* indicates that the manufacturer no longer participates in the federal rebate program and therefore the products cannot be reimbursed by Arkansas Medicaid on or after the *termination date*.

Diagram 1

Labeler ID	Labeler Name	Contract Begin Date	Contract End Date
00002	ELI LILLY AND COMPANY	01/01/1991	01/01/3000
00003	E.R. SQUIBB & SONS, LLC.	01/01/1991	01/01/3000
00004	GENENTECH, INC.	01/01/1991	01/01/3000
00006	MERCK SHARP & DOHME CORP.	01/01/1991	01/01/3000
00007	GLAXOSMITHKLINE LLC	01/01/1991	01/01/3000
00008	WYETH PHARMACEUTICALS LLC,	01/01/1991	01/01/3000
00009	PHARMACIA AND UPJOHN COMPANY LLC	01/01/1991	01/01/3000
00013	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00014	PFIZER, INC	01/01/1991	01/01/3000
00015	MEAD JOHNSON AND COMPANY	01/01/1991	01/01/3000
00023	ALLERGAN INC	01/01/1991	01/01/3000
00024	SANOFI-AVENTIS, US LLC	01/01/1991	01/01/3000
00025	PFIZER LABORATORIES DIV PFIZER INC	01/01/1991	01/01/3000
00026	BAYER HEALTHCARE LLC	01/01/1991	01/01/3000
00032	ABBVIE INC.	01/01/1991	01/01/3000

For a claim with drug HCPCS/CPT codes to be eligible for payment, the detail date of service must be prior to the *NDC termination date*. The NDC termination date represents the shelf-life expiration date of the last batch produced, as supplied on the Centers for Medicare and Medicaid Services (CMS) quarterly update. The date is supplied to CMS by the drug manufacturer or distributor.

Medicaid will deny claim details with drug HCPCS/CPT codes with a detail date of service equal to or greater than the NDC termination date.

When completing a Medicaid claim for administering a drug, indicate the HIPAA standard 11-digit NDC with no dashes or spaces. The 11-digit NDC is comprised of three (3) segments or codes: a 5-digit labeler code, a 4-digit product code, and a 2-digit package code. The 10-digit NDC assigned by the FDA printed on the drug package must be changed to the 11-digit format by inserting a leading zero (0) in one (1) of the three (3) segments. Below are examples of the FDA assigned NDC on a package changed to the appropriate 11-digit HIPAA standard format. Diagram 2 displays the labeler code as five (5) digits with leading zeros; the product code as four (4) digits with leading zeros; the package code as two (2) digits without leading zeros, using the "5-4-2" format.

Diagram 2

00123	0456	78
LABELER CODE (5 digits)	PRODUCT CODE (4 digits)	PACKAGE CODE (2 digits)

NDCs submitted in any configuration other than the 11-digit format will be rejected and denied. NDCs billed to Medicaid for payment must use the 11-digit format without dashes or spaces between the numbers.

See Diagram 3 for sample NDCs as they might appear on drug packaging and the corresponding format which should be used for billing Arkansas Medicaid:

Diagram 3

10-digit FDA NDC on PACKAGE	Required 11-digit NDC (5-4-2) Billing Format
12345 6789 1	12345678901
1111-2222-33	01111222233
01111 456 71	01111045671

B. Drug Procedure Code (HCPCS/CPT) to NDC Relationship and Billing Principles

HCPCS/CPT codes and any modifiers will continue to be billed per the policy for each procedure code. However, the NDC and NDC quantity of the administered drug is now also required for correct billing of drug HCPCS/CPT codes. To maintain the integrity of the drug rebate program, it is important that the specific NDC from the package used at the time of the procedure be recorded for billing. HCPCS/CPT codes submitted using invalid NDCs or NDCs that were unavailable on the date of service will be rejected and denied. We encourage you to enlist the cooperation of all staff members involved in drug administration to assure collection or notation of the NDC from the actual package used. It is not recommended that billing of NDCs be based on a reference list, as NDCs vary from one (1) labeler to another, from one (1) package size to another, and from one (1) time period to another.

Exception: There is no requirement for an NDC when billing for vaccines, radiopharmaceuticals, and allergen immunotherapy.

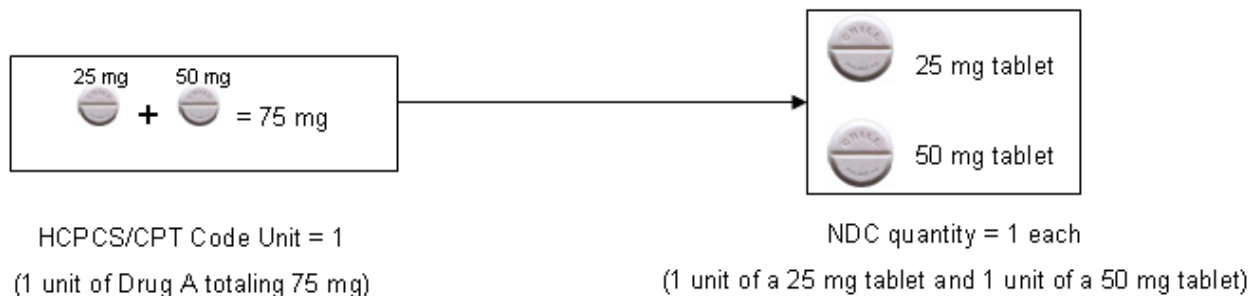
I. Claims Filing

The HCPCS/CPT codes billing units and the NDC quantity do not always have a one-to-one relationship.

Example 1: The HCPCS/CPT code may specify up to seventy-five milligrams (75mg) of the drug whereas the NDC quantity is typically billed in units, milliliters, or grams. If the patient is provided

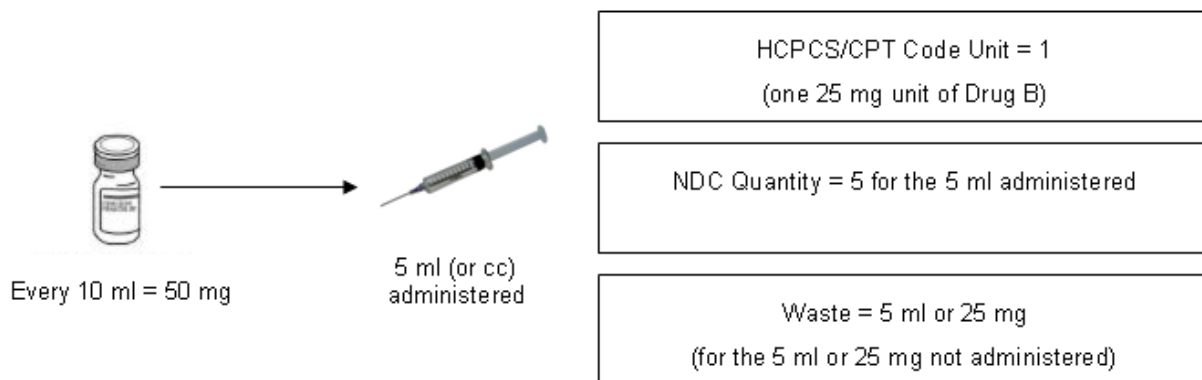
two (2) oral tablets, one at twenty-five milligrams (25mg) and one at fifty milligrams (50mg), the HCPCS/CPT code unit would be 1 (one (1) total of seventy-five milligrams (75mg)) in the example whereas the NDC quantity would be 1 each (one (1) unit of the twenty-five milligram (25mg) tablet and one (1) unit of the fifty milligram (50mg) tablet). See Diagram 4.

Diagram 4



Example 2: If the drug in the example is an injection of five milliliters (5ml) or cc of a product that was fifty milligrams (50mg) per ten milliliters (10ml) of a ten milliliter (10ml) single-use vial, the HCPCS/CPT code unit would be 1 (one (1) unit of twenty-five milligrams (25mg)) whereas the NDC quantity would be 5 (five milliliters (5ml)). In this example, five milliliters (5ml) or twenty-five milligrams (25mg) would be documented as wasted. See Diagram 5. For billing wastage, see bullets A (Electronic Claims Filing) and B (Paper Claims Filing) below.

Diagram 5



A. Electronic Claims Filing – 837P (Professional) and 837I (Outpatient)

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – submit via paper claim
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: The NDCs listed above are not the same (unless with a JW modifier). Same NDCs shall be billed on a single line with appropriate units.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

B. Paper Claims Filing – CMS-1500

Providers are instructed to bill as follows:

- One (1) NDC for a procedure – 1st/only detail shall be billed with no modifier
- Two (2) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd gets billed with a KQ modifier
- Three (3) NDCs for same procedure – 1st detail shall be billed with a KP and 2nd & 3rd detail get billed with a KQ modifier
- Four (4) or more NDCs for same procedure – 1st detail shall be billed with a KP and 2nd and subsequent details shall be billed with a KQ modifier
- Wastage of each NDC shall be billed on a separate line with a JW modifier.

NOTE: CMS definitions of modifiers:

- KP = First drug of a multiple drug unit dose formulation
- KQ = Second or subsequent drug of a multiple drug unit dose formulation
- JW = Drug wastage

Diagram 6

A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. PROCEDURE(S), SERVICE(S), OR SUPPLY(S)		D. DIAGNOSIS		E. CHARGES		F. DRUGS		G. RENDERING PROVIDER ID #	
From	To	Service	EMG	CPT/HCPCS	Modifier	Pointer	Charges	Units	Price	Qual	ID #	Qual	
N4 12345678912 UN 1.00													
01	01 22	01	01 22	11	Z1234	KP	1	25 00	1		NP	123456789	
N4 01111222223 UN 1.00													
01	01 22	01	01 22	11	Z1234	KQ	1	25 00	1		NP	123456789	
N4 44444455506 ML 3.0													
01	01 22	01	01 22	11	Z1234	KQ	1	75 00	3		NP	123456789	
N4 44444455506 ML 2.0													
01	01 22	01	01 22	11	Z1234	JW	1	50 00	2		NP	123456789	
5													
6													

II. Adjustments

Paper adjustments for paid claims filed with NDC numbers will not be accepted. Any original claim will have to be voided and a replacement claim will need to be filed. Providers have the option of adjusting a paper or electronic claim electronically.

III. Record Retention

Each provider must retain all records for five (5) years from the date of service or until all audit questions, dispute or review issues, appeal hearings, investigations, or administrative/judicial litigation to which the records may relate are concluded, whichever period is longer.

At times, a manufacturer may question the invoiced amount, which results in a drug rebate dispute. If this occurs, you may be contacted requesting a copy of your office records to include documentation pertaining to the billed HCPCS/CPT code. Requested records may include NDC

invoices showing purchase of drugs and documentation showing what drug (name, strength, and amount) was administered and on what date, to the beneficiary in question.

252.439 Billing of Multi-Use and Single-Use Vials**11-1-26**

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges.

[View or print the procedure codes for Physician Assistant services.](#)

- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered. Discarded drugs shall be billed on a separate detail line with a JW (Drug wastage) modifier.
 2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
 3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

252.440 Reserved**11-1-26****252.441 Family/Group Psychotherapy****11-1-26**

The following psychotherapy procedure codes are payable by the Arkansas Medicaid Program for family or group psychotherapy:

[View or print the procedure codes for Physician Assistant services.](#)

Procedure codes are payable when the place of service is the beneficiary’s home, the physician’s office, a hospital, or a nursing home. Procedure codes are payable when the patient is not present; however, the patient may be present during the session, when appropriate.

252.442 Radiology and Laboratory Procedure Codes**11-1-26**

The technical component radiology procedure codes listed on the Physician Assistant fee schedule are payable when performed in the office place of service (11) if the Physician Assistant provider owns the equipment. The technical component must be billed on the claim with modifier TC added to the procedure code on the claim detail.

The payment for laboratory codes listed on the Physician Assistant fee schedule is based on Clinical Laboratory Improvement Amendments (CLIA) certification. CLIA-certified providers are not the only providers who may bill for lab procedures performed in the office place of service (11). Physician Assistant providers that bill CLIA-required laboratory procedure codes must have the current CLIA certification on file with the Provider Enrollment Unit.

252.443 Other Covered Injections

11-1-26

Physician Assistants billing the Arkansas Medicaid Program for injections for treatment or immunization purposes should bill the appropriate CPT or HCPCS procedure code for the specific injection provided. The immunization procedure codes and descriptions may be found in the CPT coding book and in this section of this manual.

Providers may bill the immunization procedure codes on either the Child Health Services (EPSDT) DMS-694 claim form or the CMS-1500 form.

If the patient is scheduled for immunization only, the provider will not be permitted to bill for an office visit, but for the immunization only.

The following is an alphabetized list of injections with special instructions for coverage and billing.

[View or print the procedure codes for Physician Assistant services.](#)

* Procedure code requires paper billing.

NOTE: Where both a national code and a local code ("Z code") are available, the local code can be used only for dates of service through October 15, 2003; the national code must be used for both electronic and paper claims for dates of service after October 15, 2003. Where only a local code is available, it can be used indefinitely, but it can be billed only on a paper claim. Where only a national code is available, it can be used indefinitely for both electronic and paper claims.

252.444 Billing Procedures for Rabies Immune Globulin and Rabies Vaccine

11-1-26

The following CPT procedure codes are covered for all ages without diagnosis restrictions.

[View or print the procedure codes for Physician Assistant services.](#)

These procedure codes require billing on a paper claim with the dosage entered in the units column of the claim form for each date of service. The manufacturer's invoice must be attached to each claim. Reimbursement for each of these procedure codes includes an administration fee. Medical policy and billing procedures have not changed for these procedure codes.

252.445 Reserved

11-1-26

252.446 Reserved

11-1-26

252.447 Reserved

11-1-26

252.448 Medication Assisted Treatment and Opioid Use Disorder Treatment Drugs

11-1-26

Medication Assisted Treatment for Opioid Use Disorders is available to all qualifying Medicaid beneficiaries when provided by qualified physicians, physician assistants, or advanced practice registered nurses who are enrolled in an Arkansas Medicaid Program in which MAT services are rendered. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

Effective for dates of services on and after **October 1, 2018**, the following Healthcare Common Procedure Coding System Level II (HCPCS) procedure codes are payable:

[View or print the procedure codes for Physician Assistant services.](#)

To access prior approval of these HCPCS procedure codes when necessary, refer to the Pharmacy Memorandums, Criteria Documents and forms found at the [DHS contracted Pharmacy vendor website](#).

252.449 Influenza Virus Vaccine

11-1-26

[View or print the procedure codes for Physician Assistant services.](#)

- A. Procedure code, influenza virus vaccine, split virus, preservative free, for children six to thirty-five (6-35) months of age, is currently covered through the VFC program. Claims for Medicaid beneficiaries must be filed using modifiers **EP** and **TJ**.
- For ARKids First-B beneficiaries, use modifier **TJ**.
- B. Effective for dates of service on and after October 1, 2005, Medicaid will cover procedure code, influenza virus vaccine, split virus, and preservative free, for ages three (3) years of age and older.
1. For individuals under nineteen (19) years of age, claims must be filed using modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. For individuals nineteen (19) years of age and older, no modifier is necessary.
- C. Effective for dates of service on and after October 1, 2005, procedure code, influenza virus vaccine, live, for intranasal use, is covered. Coverage is limited to healthy individuals five through forty-nine (5-49) years of age through 49 who are not pregnant.
1. When filing claims for children five through eighteen (5-18) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, the procedure code must be billed using modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen through forty-nine (19-49) years of age.
- D. Procedure code, influenza virus vaccine, split virus, for children six through thirty-five (6-35) months of age, is covered. Modifiers **EP** and **TJ** are required.
- For ARKids First-B beneficiaries, use modifier **TJ**.
- E. Procedure code, influenza virus vaccine, split virus, for use in individuals three (3) years of age and older, will continue to be covered.
1. When filing paper claims for individuals under nineteen (19) years of age, use modifiers **EP** and **TJ**.
 2. For ARKids First-B beneficiaries, use modifier **TJ**.
 3. No modifier is required for filing claims for beneficiaries nineteen (19) years of age and older.

252.450 Obstetrical Care and Risk Management Services for Pregnancy

11-1-26

Covered Physician Assistant obstetrical services are limited to antepartum and postpartum care only. Claims for antepartum and postpartum services are filed using the appropriate office visit CPT procedure code.

A Physician Assistant may provide risk management services listed below if he or she receives a referral from the patient's physician or certified nurse-midwife and if the Physician Assistant employs the professional staff required. Complete service descriptions and coverage information may be found in Section 214.620 of this manual. The services in the list below are considered as one (1) service and are limited to thirty-two (32) cumulative units.

[View or print the procedure codes for Physician Assistant services.](#)

For an early discharge home visit, use one (1) of the applicable CPT procedure codes.

252.452 Newborn Care

11-1-26

All newborn services must be billed under the newborn's own Medicaid identification number.

The parent(s) of the newborn is responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. If the newborn is not certified as Medicaid eligible, the parent(s) is responsible for the charges incurred by the newborn.

[View or print the procedure codes for Physician Assistant services.](#)

For routine newborn care following a vaginal delivery or C-section, procedure codes must be used one (1) time to cover all newborn care visits by the attending physician, certified nurse-midwife or, if applicable, a Physician Assistant.

The newborn care procedure codes represent the initial Child Health Services (EPSDT) newborn care or screen. This screening includes the physical exam of the baby and the conference(s) with the newborn's parent(s). Payment of these codes is considered a global rate, and subsequent visits may not be billed in addition to these codes.

Procedure codes may be billed on the EPSDT screening paper form DMS-694 or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically. For information on the Child Health Service (EPSDT) Program, call the Provider Assistance Center. **[View or print Provider Assistance Center contact information.](#)**

For illness care (such as neonatal jaundice), use procedure codes. Do not use procedure codes in addition to these codes.

Note the descriptions, modifiers and required diagnosis range. The newborn care procedure codes require a modifier and a primary detail diagnosis of V30.00-V37.21 for all providers. Refer to the appropriate manual(s) for additional information about newborn screenings.

ARKids First-A (EPSDT) requires an EPSDT claim form or CMS-1500 claim form and may be billed electronically or on paper.

ARKids First-B requires a CMS-1500 claim form and may be billed electronically or on paper.

252.453 Fluoride Varnish Treatment

11-1-26

[View or print the procedure codes for Physician Assistant services.](#)

The American Dental Association (ADA) procedure code is covered by the Medicaid. The code is payable for beneficiaries under twenty-one (21) years of age. Topical Fluoride varnish application benefit is covered every six (6) months plus one (1) day for beneficiaries under twenty-one (21) years of age.

A new specialty code, FC-Fluoride Certification will be tied to provider types 01, 03, 58 and 69. These providers must send proof of their fluoride varnish certification to DHS or its designated vendor before the specialty code will be added to their file in the MMIS. **[View or print contact information to obtain the DHS or designated vendor step-by-step process for provider enrollment.](#)** After the specialty code, FC-Fluoride Certification, is added to the provider's file, the provider will be able to bill for procedure code, Topical Application of Fluoride Varnish.

Providers must check the Supplemental Eligibility Screen to verify that the topical fluoride varnish benefit of two (2) per State Fiscal Year (SFY) has not been exhausted. If further treatment is needed due to severe periodontal disease, then the beneficiary must be referred to a Medicaid dental provider.

NOTE: This service is billed on form CMS-1500 with ADA procedure code (Topical application of fluoride varnish (prophylaxis not included) – child (ages 0-20)).
[View a form CMS-1500 sample form.](#)

252.454 Tobacco Cessation Products and Counseling Services

11-1-26

- A. Tobacco cessation counseling and products are covered services to eligible Medicaid beneficiaries. Tobacco cessation products either prescribed or initiated through statewide pharmacist protocol are available without prior authorization (PA) to eligible Medicaid beneficiaries. Additional information can be found on the [DHS Contracted Pharmacy Vendor website](#) or in the [Prescription Drug Program Prior Authorization Criteria](#).

[View or print the procedure codes for Physician Assistant services.](#)

*Exempt from PCP referral requirements.

✱(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

- B. Four (4) Counseling visits per state fiscal year.
- C. Health education can include but is not limited to tobacco cessation counseling services to the parent or legal guardian of the child.
- D. Can be billed in addition to an office visit or EPSDT.
- E. Sessions do not require a PCP referral.
- F. If the beneficiary is under eighteen (18) years of age, and the parent or legal guardian smokes, he or she can be counseled as well, and the visit billed under the minor's beneficiary Medicaid number. The provider cannot prescribe meds for the parent under the child's Medicaid number. A parent or legal guardian session will count towards the four (4) counselling sessions limit described in section B above.

The provider must complete the counseling checklist and place in the patient records for audit. A copy of the checklist is available at [Be Well Arkansas Referral Form](#).

252.455 Physical Therapy Services Billing

11-1-26

Occupational therapy evaluations and services are payable only to a qualified occupational therapist. Physical therapy evaluations are not payable to the Physician Assistant. Physical therapy may be payable to the physician when directly provided in accordance with the Occupational, Physical, Speech Therapy Services Manual. The following procedure codes must be used when filing claims for physician provided therapy services. [See Glossary - Section IV](#) - for definitions of "group" and "individual" as they relate to therapy services.

[View or print the procedure codes for Physician Assistant services.](#)

A provider must furnish a full unit of service to bill Medicaid for a unit of service. Partial units are not reimbursable. Extended therapy services may be requested for physical and speech therapy, if medically necessary, for eligible Medicaid beneficiaries of all ages.

252.456 Laboratory Procedures for Highly Active Antiretroviral Therapy (HAART) 11-1-26

The following CPT procedure codes are covered for Medicaid beneficiaries.

[View or print the procedure codes for Physician Assistant services.](#)

252.457 Procedures That Require Prior Authorization 11-1-26

- A. The following procedure code requires prior authorization by the DHS or its designated vendor. (See Section 220.000 of this manual for prior authorization instructions.)
- B. The following Molecular Pathology codes require [prior authorization from DHS or its designated vendor](#).

[View or print the procedure codes for Physician Assistant services.](#)

252.460 Outpatient Hospital Services

252.461 Emergency Services 11-1-26

The appropriate CPT procedure codes should be used when billing the Physician Assistant's emergency service visits in an outpatient hospital setting.

252.462 Non-Emergency Services 11-1-26

Procedure code should be billed for a non-emergency Physician Assistant visit.

[View or print the procedure codes for Physician Assistant services.](#)

252.465 Observation Status 11-1-26

When claims are filed for services provided to a patient in "observation status," Physician Assistants must adhere to Arkansas Medicaid definitions of inpatient and outpatient. Observation status is an outpatient designation. Physician Assistants must also follow the guidelines and definitions in *Current Procedural Terminology* (CPT), under "Hospital Observation Services" and "Evaluation and Management Services Guidelines."

Arkansas Medicaid criteria determining inpatient and outpatient status:

- A. If a patient is expected to remain in the hospital for less than twenty-four (24) consecutive hours, and this expectation is realized, the hospital and the Physician Assistant should consider the patient an outpatient meaning, the patient is an outpatient unless the Physician Assistant's supervising physician has admitted him or her as an inpatient).
- B. If the Physician Assistant or hospital expects the patient to remain in the hospital for twenty-four (24) hours or more, Medicaid deems the patient admitted at the time the patient's medical record indicates the existence of such an expectation, though the Physician Assistant's supervising physician has not yet formally admitted the patient.
- C. Medicaid also deems a patient admitted to inpatient status once the patient has remained in the hospital for twenty-four (24) consecutive hours, even if the Physician Assistant, the supervising physician, or the hospital had no prior expectation of a stay of that or greater duration

252.466 Billing Examples 11-1-26

The following table gives examples of appropriate Physician Assistant claims for several common hospital scenarios. In the table, instructions under the headings “PHYSICIAN ASSISTANT MAY BILL...” do not necessarily include all services that the Physician Assistant may bill. For instance, the provider may bill for interpretation of X-rays or diagnostic tests, though the table below does not indicate this. The purpose of this table is to illustrate Arkansas Medicaid observation status policy and to give guidance for filing claims related to evaluation and management services.

Arkansas Medicaid Observation Status Policy Illustration			
PATIENT IS ADMITTED TO OBSERVATION	PATIENT IS	PHYSICIAN ASSISTANT MAY BILL FOR TUESDAY SERVICES:	PHYSICIAN ASSISTANT MAY BILL FOR WEDNESDAY SERVICES:
Tuesday, 3:00 PM	Still in Observation Wednesday, 3:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM	Discharged Wednesday, 12:00 PM (noon)	Appropriate level of Initial Observation Care	Observation care Discharge Day Management
Tuesday, 3:00 PM	Discharged Wednesday, 4:00 PM	Appropriate level of Initial Observation Care	Appropriate level of Initial Hospital Care
Tuesday, 3:00 PM, after outpatient surgery	Discharged Wednesday, 10:00 AM	Outpatient surgery	No evaluation and Management Services
Tuesday, 3:00 PM, after exam in Emergency Department—emergency or non-emergency	Discharged Tuesday, 7:00 PM	Appropriate level of Initial Observation Care	Not Applicable; Patient was Discharged Tuesday

252.470 Prior Authorization Control Number

11-1-26

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare

11-1-26

When a beneficiary is dually eligible for Medicare and Medicaid and is provided services that are covered by both Medicare and Medicaid, Medicaid will not reimburse those services if Medicare has not been billed prior to Medicaid billing. The beneficiary cannot be billed for the charges. See Section 142.700 for detailed information regarding Medicare participation and Sections 332.000 through 332.300 for detailed information regarding Medicare-Medicaid Crossover claims procedures.

252.481 Services Prior to Medicare Entitlement

11-1-26

Services that have been denied by Medicare with the explanation “Services Prior to Medicare Entitlement” may be filed with Medicaid. These services should be filed for processing on the

CMS-1500 claim form and forwarded to the Inquiry Unit. [View or print the Inquiry Unit contact information.](#)

These services can usually be filed electronically unless they are covered by Medicare and the beneficiary was sixty-five (65) or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims so they may receive special handling.

252.482 Services Not Medicare Approved

11-1-26

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services not covered by Medicare but covered by Medicaid. These exceptions may require special handling.

252.483 Drug Treatment for Pediatric PANS and PANDAS

11-1-26

- A. Effective for dates of service on and after 6/1/2022, drug treatment is available to qualifying Medicaid beneficiaries when specified conditions are met for one (1) or both of the following conditions:
 - 1. Pediatric acute-onset neuropsychiatric syndrome (PANS),
 - 2. Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS).
- B. The drug treatments include off-label treatments, including without limitation intravenous immunoglobulin (IVIG).
- C. Medicaid will cover drug treatment for PANS or PANDAS under the following conditions:
 - 1. The drug treatment must be authorized under a Treatment Plan; and
 - 2. The Treatment Plan must be established by the approved PANS/PANDAS provider.
- D. A Prior Authorization (PA) must be obtained for each treatment. Providers must submit the current Treatment Plan to the Quality Improvement Organization (QIO) along with the request for Prior Authorization. [View or print contact information for the QIO.](#)
- E. The authorized procedure codes and required modifiers are found in the following link:

[View or print the procedure codes for Physician Assistant services, including PANS and PANDAS procedure codes.](#)

252.484 Injections, Therapeutic and/or Diagnostic Agents

11-1-26

Physician Assistants shall administer injections, therapeutic agents, and diagnostic agents according to the rules set forth in the [Medicaid Physician provider manual](#) and within the scope of practice guidelines.

[View or print the procedure codes for Physician Assistant services.](#)

TOC required

211.000 Scope

6-1-0911-1-
26

~~The Medical Assistance (Medicaid) Program~~ is designed to assist eligible ~~Medicaid~~ beneficiaries in obtaining ~~medical~~health care within the guidelines specified in this manual. All Medicaid benefits are based on medical necessity. See the Glossary for the definition of medical necessity.

- A. A provider-based rural health clinic is one which is an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare and which is licensed, governed, and supervised with other departments of the facility.
- B. An independent (free-standing) rural health clinic is one that participates in Medicare and is not provider-based.
- C. Visit is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse specialist, or other specialized nurse practitioner whose services are reimbursed under the rural health clinic payment method. Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

211.100 Rural Health Clinic Core Services

2-1-2411-1-
26

Rural Health Clinic core services are defined as follows:

- A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;
- B. Services and supplies furnished "incident to" a physician's professional services;
- C. Services provided by non-physicians, such as services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, and specialized nurse practitioners when the provider is legally:
 - 1. employed by, or receiving compensation from a rural health clinic;
 - 2. under the medical supervision of a physician; and
 - 3. acting in accordance with any medical orders prepared by a physician for the care and treatment of a patient; prepared by a physician; and
 - 4. ~~or~~ acting within their scope of practice by to providing perform services ~~they are~~ legally permitted by the state to perform by the state in which the service is provided, if the services would be covered whenif furnished by a physician;
- D. Services and supplies that are furnished as an incident to professional services ~~furnished provided~~ by a nurse practitioner, physician assistant, clinical nurse specialist, nurse midwife, or other specialized nurse practitioner;
- E. Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70. Visiting nurse services on a part-time or intermittent basis to home-bound patients in areas in which there is a shortage of home health agencies.

~~Note: For purposes of visiting nurse care, a home-bound patient is one who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. Institutions, such as a hospital or nursing care facility, are not considered a patient's residence.~~

~~Note: A patient's place of residence is where he or she lives, unless he or she is in an institution such as a nursing facility, hospital, or intermediate care facility for individuals with intellectual disabilities (ICF/IID); and~~

- F. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to ~~all~~ qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

211.220 Services and Supplies "Incident To" a Nurse Practitioner's, Clinical Nurse Specialist's, or Physician Assistant's Service **40-13-0311-1-26**

Services and supplies "incident to" ~~a~~ nurse practitioner's, clinical nurse specialist, or physician assistant's services are covered if the service or supply is:

- A. ~~Of a~~ type commonly furnished in physicians' offices;
- B. ~~Of a~~ type commonly furnished without charge or included in the RHC's bill;
- C. Furnished as an incidental, although integral, part of the professional services of a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant;
- D. Furnished under the direct, personal supervision of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, specialized nurse practitioner, or a physician and
- E. ~~In the case of a~~ service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, or specialized nurse practitioner only if such a person is permitted to supervise such services under the written policies governing the RHC.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

212.210 Rural Health Clinic (RHC) Non-Core Services **40-13-0311-1-26**

- A. The following services are not ~~to be defined as~~ Rural Health Clinic (RHC) core services.
 1. Emergency and non-emergency outpatient hospital visits,
 2. Inpatient hospital visits,
 3. Surgeries performed in the inpatient or outpatient hospital or in an ambulatory surgical center,
 4. Technical components of radiology procedures, and
 5. Technical components of electrocardiograms and echocardiography.
- B. Inpatient and outpatient hospital visits, home and nursing facility visits, and other off-site visits remain core services if the physician, clinical nurse specialist, nurse midwife, or nurse practitioner ~~must see patients at sites away from the RHC and is compensated by the RHC as a condition of his or her employment by, or contract with, the RHC, see patients at sites away from the RHC and is compensated by the RHC.~~

- C. Physicians, physician assistants, clinical nurse specialists, nurse midwives, and nurse practitioners enrolled in the Arkansas Medicaid Program may bill for RHC non-core services according to the guidelines in their respective Medicaid manuals.
- D. Rural Health Clinics ~~desiring~~ to bill for RHC non-core physician services must enroll with Arkansas Medicaid as physician group providers, even if they intend to bill for the services of only one physician. See Section II of the Arkansas Medicaid **Physician/Independent Lab/CRNA/Radiation Therapy Center** manual for participation requirements.
- E. Rural Health Clinics ~~desiring to bill~~ for RHC non-core physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner services must enroll with Arkansas Medicaid as nurse practitioner and physician assistant group providers, as appropriate, even if they only intend to bill for the services of only one (1) physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner. See Section II of the ~~Arkansas~~ Medicaid **Physician Assistant, Clinical Nurse Specialist, Certified Nurse-Midwife, and Nurse Practitioner** manuals for participation requirements.

213.000 Staff Requirements and Responsibilities

4-4-1811-1-
26

- A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants, clinical nurse specialists, certified nurse-midwives, or nurse practitioners. The physicians, physician assistants, clinical nurse specialists, nurse midwives, or nurse practitioners may be the owners of the RHC, ~~and/or~~ under agreement with the RHC, or both, to carry out the responsibilities required.
- B. The staff may include ancillary personnel who are supervised by the professional staff.
- C. A physician, physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner must be available to furnish patient care services at times the RHC operates. These staff must be available to furnish patient care services at least fifty percent (50%) of the time the RHC operates.
- D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician ~~also~~ must participate in developing, executing and periodically reviewing policies, services, and patient records; and must provide medical orders and medical care services to patients of the RHC.
- E. The physician assistant, clinical nurse specialist, nurse midwife, and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.
- F. The physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner must perform the following functions, to the extent when they are not being performed by a physician does not perform them:
 1. Provide services ~~in accordance with~~ according to RHC policies;
 2. Arrange for services or refer patient the beneficiary for services that cannot be provided by the RHC; and
 3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
 4. Some services such as personal care require an Independent Assessment. Please refer to the **Independent Assessment Guide** for related information.

216.000 Limitations and/or Non-Covered Services

10-13-0311-
1-26

RHC services are subject to ~~the~~ limitation and coverage restrictions that exist for medical services provided in other settings. Services not covered by ~~the~~ Arkansas Medicaid Program include, ~~but are not limited to~~ without limitation, the following:

- A. The services of nurse practitioners, physician assistants, nurse midwives, clinical nurse specialist, or specialized nurse practitioners if state law or regulations require that the services be performed under a physician's order and no such order was prepared.
- B. Services that are not considered medically necessary.
- C. Services that are not properly documented.
- D. Visits in which a direct relationship does not exist between the patient and a physician, a physician assistant, a clinical nurse specialist, or nurse practitioner (~~e.g., such as a~~ visit to pick up a prescription, telephone consultation, and so forth).
- E. Cosmetic surgery performed primarily for aesthetic purposes ~~only~~ (~~e.g., such as~~ ear piercing, tattoo removal, etc. and so forth).
- F. Well child ~~care visits~~, routine physical examinations, or examinations for school. (See the Child Health Services (EPSDT) Manual, Section II, for coverage of these services and for billing instructions:).
- G. Dietary counseling.
- H. Most screening-type services unless being used to make a diagnosis (~~e.g., such as~~ hypertension H₁—screening, diabetes screening, hair analysis, etc. and so forth).
- I. Literature, booklets, and other educational services.

218.100 RHC Encounter Benefit Limits

117-1-265

- A. Medicaid clients-beneficiaries under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic (RHC) encounter benefit limit.
- B. Beneficiaries twenty-one (21) years of age or older ~~Have a~~ benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, ~~has been established for clients twenty-one (21) years or older~~. The following services are counted toward the per SFY encounter benefit limit:
 1. ~~Provider~~Physician visits in the office, client's home, or nursing facility;
 2. Certified nurse-midwife visits;
 3. RHC encounters;
 4. Medical services provided by a dentist;
 5. Medical services provided by an optometrist;
 6. Advanced practice registered nurse (APRN) services in the office, client's beneficiary's home, or nursing facility; ~~and~~
 7. Federally qualified health center (FQHC) encounters;
 8. Physician assistant services; and
 9. Certified nurse specialist services in the office, client's home, or nursing facility.

~~Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.~~

~~The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis (View ICD OUD Codes).~~

Extensions of the benefit limit will be considered for services beyond the established ~~benefit~~ limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

TOC required**211.000 Scope****11-1-26**

Medicaid is designed to assist eligible beneficiaries in obtaining health care within the guidelines specified in this manual. All Medicaid benefits are based on medical necessity. See the Glossary for the definition of medical necessity.

- A. A provider-based rural health clinic is one which is an integral part of a hospital, skilled nursing facility, or home health agency that participates in Medicare and which is licensed, governed, and supervised with other departments of the facility.
- B. An independent (free-standing) rural health clinic is one that participates in Medicare and is not provider-based.
- C. Visit is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse specialist, or other specialized nurse practitioner whose services are reimbursed under the rural health clinic payment method. Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

211.100 Rural Health Clinic Core Services**11-1-26**

Rural Health Clinic core services are defined as follows:

- A. Professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services;
- B. Services and supplies furnished "incident to" a physician's professional services;
- C. Services provided by non-physicians, such as services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, and specialized nurse practitioners when the provider is legally:
 - 1. employed by or receiving compensation from a rural health clinic;
 - 2. under the medical supervision of a physician; and
 - 3. acting in accordance with any medical orders prepared by a physician for the care and treatment of a patient; or acting within their scope of practice to perform services legally permitted by the state in which the service is provided, if the services would be covered when furnished by a physician;
- D. Services and supplies that are furnished as an incident to professional services provided by a nurse practitioner, physician assistant, clinical nurse specialist, nurse midwife, or other specialized nurse practitioner;
- E. Part-time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70.
- F. Medication Assisted Treatment (MAT) for Opioid or Alcohol Use Disorders is available to qualifying Medicaid beneficiaries. All rules and regulations promulgated within the Physician's provider manual for provision of this service must be followed.

211.220 Services and Supplies “Incident To” a Nurse Practitioner’s, Clinical Nurse Specialist’s, or Physician Assistant’s Service 11-1-26

Services and supplies “incident to” nurse practitioner, clinical nurse specialist, or physician assistant services are covered if the service or supply is:

- A. A type commonly furnished in physicians’ offices;
- B. A type commonly furnished without charge or included in the RHC’s bill;
- C. Furnished as an incidental, although integral, part of the professional services of a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant;
- D. Furnished under the direct, personal supervision of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, specialized nurse practitioner, or a physician and
- E. A service, furnished by a member of the clinic’s health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a nurse practitioner, clinical nurse specialist, physician assistant, nurse midwife, or specialized nurse practitioner only if such a person is permitted to supervise such services under the written policies governing the RHC.

Only drugs and biologicals that cannot be self-administered are included within the scope of this benefit.

212.210 Rural Health Clinic (RHC) Non-Core Services 11-1-26

- A. The following services are not defined as Rural Health Clinic (RHC) core services.
 - 1. Emergency and non-emergency outpatient hospital visits,
 - 2. Inpatient hospital visits,
 - 3. Surgeries performed in the inpatient or outpatient hospital or in an ambulatory surgical center,
 - 4. Technical components of radiology procedures, and
 - 5. Technical components of electrocardiograms and echocardiography.
- B. Inpatient and outpatient hospital visits, home and nursing facility visits, and other off-site visits remain core services if the physician, clinical nurse specialist, nurse midwife, or nurse practitioner see patients at sites away from the RHC and is compensated by the RHC as a condition of his or her employment by, or contract with, the RHC.
- C. Physicians, physician assistants, clinical nurse specialists, nurse midwives, and nurse practitioners enrolled in the Arkansas Medicaid Program may bill for RHC non-core services according to the guidelines in their respective Medicaid manuals.
- D. Rural Health Clinics to bill for RHC non-core physician services must enroll with Arkansas Medicaid as physician group providers, even if they intend to bill for the services of only one physician. See Section II of the Arkansas Medicaid **Physician/Independent Lab/CRNA/Radiation Therapy Center** manual for participation requirements.
- E. Rural Health Clinics billing for RHC non-core physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner services must enroll with Arkansas Medicaid as nurse practitioner and physician assistant group providers, as appropriate, even if they only bill for the services of one (1) physician assistant, clinical nurse specialist, nurse midwife, or

nurse practitioner. See Section II of the Medicaid [Physician Assistant](#), [Clinical Nurse Specialist](#), [Certified Nurse-Midwife](#), and [Nurse Practitioner](#) manuals for participation requirements.

213.000 Staff Requirements and Responsibilities

11-1-26

- A. The RHC must have a health care staff that includes one or more physicians and one or more physician assistants, clinical nurse specialists, certified nurse-midwives, or nurse practitioners. The physicians, physician assistants, clinical nurse specialists, nurse midwives, or nurse practitioners may be the owners of the RHC, under agreement with the RHC, or both, to carry out the responsibilities required.
- B. The staff may include ancillary personnel who are supervised by the professional staff.
- C. A physician, physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner must be available to furnish patient care services at times the RHC operates. The staff must be available to furnish patient care services at least fifty percent (50%) of the time the RHC operates.
- D. The physician must provide medical direction for the RHC activities and consultation for the medical supervision of the health care staff. The physician must participate in developing, executing and periodically reviewing policies, services, and patient records; and must provide medical orders and medical care services to patients of the RHC.
- E. The physician assistant, clinical nurse specialist, nurse midwife, and nurse practitioner, as members of the RHC staff, must participate in the development, execution and periodic review of the written policies governing the services the RHC furnishes and participate with the physician in a periodic review of patients' health records.
- F. The physician assistant, clinical nurse specialist, nurse midwife, or nurse practitioner must perform the following functions, when a physician does not perform them:
 - 1. Provide services according to RHC policies;
 - 2. Arrange for services or refer the beneficiary for services that cannot be provided by the RHC; and
 - 3. Assure adequate patient health records are maintained and transferred as required when patients are referred.
 - 4. Some services such as personal care require an Independent Assessment. Please refer to the [Independent Assessment Guide](#) for related information.

216.000 Limitations and/or Non-Covered Services

11-1-26

RHC services are subject to limitation and coverage restrictions that exist for medical services provided in other settings. Services not covered by Arkansas Medicaid include, without limitation, the following:

- A. The services of nurse practitioners, physician assistants, nurse midwives, clinical nurse specialist, or specialized nurse practitioners if state law or regulations require that the services be performed under a physician's order and no such order was prepared.
- B. Services that are not considered medically necessary.
- C. Services that are not properly documented.
- D. Visits in which a direct relationship does not exist between the patient and a physician, a physician assistant, a clinical nurse specialist, or nurse practitioner (such as a visit to pick up a prescription, telephone consultation, and so forth).

- E. Cosmetic surgery performed primarily for aesthetic purposes (such as ear piercing, tattoo removal, and so forth).
- F. Well child visits, routine physical examinations, or examinations for school. (See the [Child Health Services \(EPSDT\) Manual, Section II](#), for coverage of these services and for billing instructions).
- G. Dietary counseling.
- H. Most screening-type services unless being used to make a diagnosis (such as hypertension screening, diabetes screening, hair analysis, and so forth).
- I. Literature, booklets, and other educational services.

218.100 RHC Encounter Benefit Limits**11-1-26**

- A. Medicaid beneficiaries under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic (RHC) encounter benefit limit.
- B. Beneficiaries twenty-one (21) years of age or older have a benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30. The following services are counted toward the per SFY encounter benefit limit:
 - 1. Physician visits in the office, client's home, or nursing facility;
 - 2. Certified nurse-midwife visits;
 - 3. RHC encounters;
 - 4. Medical services provided by a dentist;
 - 5. Medical services provided by an optometrist;
 - 6. Advanced practice registered nurse (APRN) services in the office, beneficiary's home, or nursing facility;
 - 7. Federally qualified health center (FQHC) encounters;
 - 8. Physician assistant services; and
 - 9. Certified nurse specialist services in the office, client's home, or nursing facility.

Extensions of the benefit limit will be considered for services beyond the established limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

TOC required**216.000 Medical Procedures Billable by Optometrists****12-1-0611-1-26**

Optometrists are allowed to bill for certain ~~procedures for office~~ medical services, procedures, and special services previously payable only to physicians.

The ~~office~~ medical services provided by an optometrist ~~will be~~ limited to ~~twelve sixteen (16)~~ visits per state fiscal year (SFY) for ~~individuals beneficiaries age~~ twenty-one (21) years of age and over. The benefit limit ~~will be used~~ in conjunction with ~~four following~~ other programs:- ~~These programs are~~ physicians' services, physician assistant services, medical services provided by dentists, rural health clinic services, federally qualified health center services, clinical nurse specialist services, advanced practice registered nurse (APRN) services, and certified nurse-midwife services. Beneficiaries will be allowed ~~twelve sixteen (16)~~ visits per ~~state fiscal year~~ SFY for ~~office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services, certified nurse-midwife services~~ for any combination ~~there of the five~~. Extensions beyond the ~~twelve visit~~ limit may be provided if medically necessary. ~~Office m~~Medical services for beneficiaries ~~under age~~ twenty-one (21) years of age in the Child Health Services (EPSDT) Program are not benefit limited. Procedure codes, description of services, and special billing instructions are located in Section 240.000 of the ~~is~~ manual.

All beneficiaries of vision and medical ~~eye care of the eye~~ may have direct access to optometrists as primary eye care providers, independent of the primary care provider ~~(e.g., such as physician, Federally Qualified Health Center (FQHC), etc.)~~ clinical nurse specialist, APRN, and so forth.

216.100 Extension of Benefits for ~~Office~~ Medical Services Provided by an Optometrist**10-13-0311-1-26**

Extensions of benefits beyond the ~~twelve sixteen (16)~~-visit limit for ~~individuals beneficiaries age~~ twenty-one (21) years of age and over may be provided, if medically necessary, ~~for office medical services provided by an optometrist and in conjunction with four other programs. Those programs are physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Medical services provided for the following diagnoses do not require an extension of the limit: malignant neoplasm, HIV/AIDS, renal failure, pregnancy, or Opioid Use Disorder when services are part of a medication assisted treatment plan.~~

232.000 Rate Appeal Review Process**9-1-0811-1-26**

A provider may request ~~reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.~~

~~If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services, which will include one member of the Division of~~

~~Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.~~

~~The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). Refer to Section I, 110.400 of the manual to get instructions for requesting a review.~~

243.150 — Office Medical Services

2-1-22

~~The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.~~

~~Office medical services covered in the Visual Care Program are limited to the following procedure codes:~~

~~**View or print the procedure codes for Vision services.**~~

TOC required**216.000 Medical Procedures Billable by Optometrists 11-1-26**

Optometrists are allowed to bill for certain medical services, procedures, and special services previously payable only to physicians.

The medical services provided by an optometrist are limited to sixteen (16) visits per state fiscal year (SFY) for beneficiaries twenty-one (21) years of age and over. The benefit limit is in conjunction with following other programs: physician services, physician assistant services, medical services provided by dentists, rural health clinic services, federally qualified health center services, clinical nurse specialist services, advanced practice registered nurse (APRN) services, and certified nurse-midwife services. Beneficiaries will be allowed sixteen (16) visits per SFY for any combination thereof. Extensions beyond the limit may be provided if medically necessary. Medical services for beneficiaries twenty-one (21) years of age in the Child Health Services (EPSDT) Program are not benefit limited. Procedure codes, description of services, and special billing instructions are located in Section 240.000 of the manual.

All beneficiaries of vision and medical care of the eye may have direct access to optometrists as primary eye care providers, independent of the primary care provider such as physician, clinical nurse specialist, APRN, and so forth.

216.100 Extension of Benefits for Medical Services Provided by an Optometrist 11-1-26

Extensions of benefits beyond the sixteen (16)-visit limit for beneficiaries twenty-one (21) years of age and over may be provided, if medically necessary. Medical services provided for the following diagnoses do not require an extension of the limit: malignant neoplasm, HIV/AIDS, renal failure, pregnancy, or Opioid Use Disorder when services are part of a medication assisted treatment plan.

232.000 Rate Review Process 11-1-26

A provider may request review of a program rate policy or procedure by writing to the Director, Division of Medical Services (DMS). [Refer to Section I, 110.400](#) of the manual to get instructions for requesting a review.

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AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: ~~October 1, 2023~~ July 1, 2026

CATEGORICALLY NEEDY

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. ~~Outpatient hospital services include the following:~~

- ~~• non-emergency outpatient hospital and related physician and nurse practitioner services;~~
- ~~and~~
- ~~• outpatient hospital therapy and treatment services and related physician and nurse practitioner services.~~

For services beyond the twelve (12)-visit limit, an extension of benefits ~~will~~ may be provided ~~if medically necessary following the medical necessity review process described in the state's provider manual. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment Plan; and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.~~

Outpatient hospital services are not benefit-limited for ~~recipients in~~ beneficiaries eligible for the Child Health Services Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
~~Programs~~ services.

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AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

CATEGORICALLY NEEDY

Revised: July 1, 2026

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30.

For services beyond the twelve (12) visit limit, an extension of benefits may be provided following the medical necessity review process described in the state's provider manual.

Outpatient hospital services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

Revised: July 1, 20~~22~~2022

CATEGORICALLY NEEDY

2.b. Rural Health Clinic (RHC) Services

Rural ~~health clinic~~Health Clinic (RHC) services are limited to sixteen (16) encounters a year for ~~clients~~beneficiaries twenty-one (21) years of age and older. This yearly limit is based on the State Fiscal Year (July ~~1~~ through June 30). ~~The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse-midwife services, federally-qualified health center encounters, and advanced practice registered nurse services, or a combination of the seven.~~

Extensions of the benefit limit ~~will be~~are available if medically necessary. ~~Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients~~Beneficiaries eligible for under-age twenty-one (21) in the Child Health Services-Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program~~services~~ are not benefit-limited.

~~Rural health clinic core RHC services are defined as follows: include Medicare core services and any other ambulatory service included in the state plan if the RHC offers such a service (e.g. dental, optometrist, etc.). The "other ambulatory services" provided by the RHC will count against the limit established in the plan for that service. For services beyond the benefit limit, an extension of benefits may be provided following the medical necessity review process described in the state's provider manual.~~

- ~~1. Physicians' services, advanced practice registered nurse's services, and physician assistant services when properly supervised;~~
- ~~2. Services and supplies furnished as an incident to professional services (services and supplies "incident to" the professional services of physicians, physician assistants or advanced practice registered nurses are those which are commonly furnished in connection with these professional services, are generally furnished in the rural health center office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services);~~
- ~~3. Clinical psychologist services;~~
- ~~4. Clinical social worker services;~~

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

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CATEGORICALLY NEEDY

2.b. Rural Health Clinic (RHC) Services

Rural Health Clinic (RHC) services are limited to sixteen (16) encounters a year for beneficiaries twenty-one (21) years of age and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30).

Extensions of the benefit limit are available if medically necessary. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.

RHC services include Medicare core services and any other ambulatory service included in the state plan if the RHC offers such a service (e.g. dental, optometrist, etc.). The “other ambulatory services” provided by the RHC will count against the limit established in the plan for that service. For services beyond the benefit limit, an extension of benefits may be provided following the medical necessity review process described in the state’s provider manual.

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2.b. Rural Health Clinic Services

~~5. Services of nurse midwives~~

~~6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).~~

~~Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the Rural health clinic offers such a service (e.g. dental, visual, etc.). The “other ambulatory services” that are provided by the Rural health clinic will count against the limit established in the plan for that service.~~

~~Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.~~

2.c. Federally Qualified Health Center (FQHC) Services

Federally ~~qualified health center~~ Qualified Health Center (FQHC) services and other ambulatory services ~~that~~ are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA-HCFA – Pub. 45-4).

FQHC services include Medicare core services and any other ambulatory services included in the state plan if the FQHC offers such a service (e.g. dental, etc.).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years of age or older. ~~The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.~~

~~For federally qualified health center core services beyond the benefit limit, extensions~~ Extensions of the benefit limit are ~~will be~~ available if medically necessary. Beneficiaries ~~under age twenty-one (21) in the Child Health Services eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program services~~ are not benefit-limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

~~Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the visit is part of a Medication Assisted Treatment plan.~~

The “other ambulatory services” provided by the FQHC will count against the limit established in the plan for that service. For services beyond the benefit limit for those services, an extension of benefits may be provided following the medical necessity review process described in the state’s provider manual.

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2.c. Federally Qualified Health Center (FQHC) Services

Federally Qualified Health Center (FQHC) services and other ambulatory services are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA – Pub. 45-4).

FQHC services include Medicare core services and any other ambulatory services included in the state plan if the FQHC offers such a service (e.g. dental, etc.).

Federally qualified health center services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years of age or older.

Extensions of the benefit limit are available if medically necessary. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

The “other ambulatory services” provided by the FQHC will count against the limit established in the plan for that service. For services beyond the benefit limit for those services, an extension of benefits may be provided following the medical necessity review process described in the state’s provider manual.

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Revised: July 1, 2026—~~October-~~
~~Revised:~~

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RESERVED

~~2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4). (Continued)~~

~~Covered FQHC core services are defined as follows:~~

- ~~• physician services;~~
- ~~• services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);~~
- ~~• Immunizations provided based on recommendations of the Advisory Committee on Immunization Practices (ACIP) and their administration;~~
- ~~• physician assistant services;~~
- ~~• nurse practitioner services;~~
- ~~• clinical psychologist services;~~
- ~~• clinical social worker services;~~
- ~~• licensed certified social worker services;~~
- ~~• licensed professional counselor services;~~
- ~~• licensed mental health counselor services;~~
- ~~• licensed marriage and family therapist services;~~
- ~~• services and supplies incident to clinical psychologist, clinical social worker, licensed certified social worker, licensed professional counselor, licensed mental health counselor, and licensed marriage and family therapist services as would otherwise be covered if furnished by or incident to physician services; and~~
- ~~• part time or intermittent nursing care and related medical supplies (home health) which meets the definition found at 42 CFR 440.70.~~

~~FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.~~

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CATEGORICALLY NEEDY

RESERVED

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5. a. ~~Physicians' services~~Services, whether furnished in the office, the client's home, a hospital, a skilled nursing facility, or elsewhere
- Physicians' services are furnished by a physician within the scope of practice of medicine or osteopathy as defined by State law; and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.
- Physicians' services provided in the office, a beneficiary's home, a hospital, a skilled nursing facility, or elsewhere are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries twenty-one (21) years of age or older.
- For services beyond the established visit limit, extensions will be available following the medical necessity review process described in the state's provider manual.
- The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurses, Rural Health Clinics, medical services furnished by dentists, medical services furnished by optometrists, certified nurse midwives, physician assistants, clinical nurse specialists, Federally Qualified Health Centers, or any combination thereof.
- Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
- Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, advance practice registered nurse's office, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit of sixteen (16) per SFY. Extensions of the benefit limit will be available if medically necessary following the medical necessity review process described in the state's provider manual.
- Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.
- ~~(1) For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's home, a nursing home, or elsewhere are limited to sixteen (16) visits per state fiscal year (SFY) (July 1 through June 30).~~
- ~~(a) Benefit Limit Details~~
- ~~The benefit limit will be considered in conjunction with the benefit limit established for rural health clinic, federally qualified health center, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and advanced practice registered nurse or a combination of the seven. Clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit limited.~~
- ~~(b) Extension of Benefits~~
- ~~For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, advanced practice registered nurse, or rural health clinic core services beyond the benefit limit, extensions will be available if medically necessary.~~
- ~~(i) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.~~
- ~~(ii) Additionally, physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.~~
- ~~(c) Special Exceptions~~
- ~~(i) Each attending physician/dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.~~
- ~~(ii) Surgical procedures which are generally considered to be elective require a prior authorization from the Utilization Review Section.~~
- ~~(iii) Desensitization injections Refer to Attachment 3.1 A, Item 4.b. (12).~~
- ~~(iv) Organ transplants are covered as described in Attachment 3.1 E.~~

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5. a. Physicians' Services

Physicians' services are furnished by a physician within the scope of practice of medicine or osteopathy as defined by State law; and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Physicians' services provided in the office, a beneficiary's home, a hospital, a skilled nursing facility, or elsewhere are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries twenty-one (21) years of age or older.

For services beyond the established visit limit, extensions will be available following the medical necessity review process described in the state's provider manual.

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurses, Rural Health Clinics, medical services furnished by dentists, medical services furnished by optometrists, certified nurse midwives, physician assistants, clinical nurse specialists, Federally Qualified Health Centers, or any combination thereof.

Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, advance practice registered nurse's office, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit of sixteen (16) per SFY. Extensions of the benefit limit will be available if medically necessary following the medical necessity review process described in the state's provider manual.

Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

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2026

Revised: ~~April 10, 2018~~ July 1,

CATEGORICALLY NEEDY

~~5. a. Physicians' Services (Continued)~~

- ~~(6) Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, patient's home, hospital or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1). Extensions of the benefit limit will be provided if medically necessary for recipients.~~
- ~~(7) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.~~

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).

"Medical and surgical services of a dentist" means medical and surgical services furnished, by a doctor of dental medicine or dental surgery if the services are services that:

1. If furnished by a physician, would be considered physician's services.
2. Under the law of the State where they are furnished, may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
3. Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services."

Medical services furnished by a dentist are limited to ~~twelve-sixteen~~ (16) visits per State Fiscal Year (July 1 through June 30) for recipients-beneficiaries aged twenty-one (age 21) years and older. Extensions of the benefit limit may be provided if medically necessary, following the medical necessity review process described in the state's provider manual.

The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, rural health clinic services, office medical services furnished by an optometrist and certified nurse midwife services. Recipients will be allowed twelve (12) visits per State Fiscal Year for medical services furnished by a dentist, physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services or ~~advanced practice nurse or registered nurse practitioner services or a combination of the six.~~ For physicians' services, medical services provided by a dentist, office medical services furnished by an optometrist, certified nurse midwife services or rural health clinic core services beyond the 12 visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Recipients under age 21 in the Child Health Services (EPSDT) Program are not benefit limited. Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Surgical services furnished by a dentist are not benefit-limited.

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5. b. Medical and surgical services furnished by a dentist in accordance with Section 1905 (a)(5)(B) of the Act.

“Medical and surgical services of a dentist” means medical and surgical services furnished, by a doctor of dental medicine or dental surgery if the services are services that:

1. If furnished by a physician, would be considered physician's services.
2. Under the law of the State where they are furnished, may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
3. Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services.”

Medical services furnished by a dentist are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries aged twenty-one (21) years and older. Extensions of the benefit limit may be provided if medically necessary, following the medical necessity review process described in the state's provider manual.

Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Surgical services furnished by a dentist are not benefit-limited.

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)
- b. Optometrists¹ Services (Continued)
- (2) One eye exam every twelve (12) months for eligible ~~client-beneficiaries~~ under ~~twenty-one (21)~~ years of age in the ~~Child Health Services~~Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Extensions of the benefit limit will be available if medically necessary for ~~clients-beneficiaries~~ in the ~~Child Health Services (EPSDT) Program~~.
- (3) ~~Medical Office-medical~~ services provided by an optometrist are limited to ~~twelve (12)-sixteen (16)~~ visits per State Fiscal Year (July 1 through June 30) for ~~clients-beneficiaries aged~~ twenty-one (21) years or older.
- ~~The benefit limit will be in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, Federally Qualified Health Center services, certified nurse midwife services, and advanced practice registered nurses, or a combination of the seven. For services beyond the benefit limit, extensions will may be available if medically necessary, following the medical necessity review process described in the state's provider manual. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited. Certain services, specified in the appropriate provider manual, are not counted toward the limit.~~
- c. Chiropractors¹ Services
- (1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.
- (2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.
- (3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid ~~clients-beneficiaries aged~~ twenty-one (21) years or older. ~~Services provided to clients under age twenty-one (21) in the Child Health Services (EPSDT) Program are not benefit-limited. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.~~
- (4) Effective for dates of service on or after January 1, 2018, chiropractic services do not require a referral by the client's primary care provider (PCP).
- d. Advanced Practice Registered Nurses (APRN)
- Advanced practice registered nurses include without limitation licensed advanced practice registered nurses who hold specialized certifications such as clinical nurse specialist, certified nurse midwife, who are practicing within the scope of their APRN license according to state law.
- For ~~clients-beneficiaries aged~~ twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
- ~~The benefit limit will be in conjunction with the benefit limit established for physicians' services, rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services and federally qualified health center, or a combination of the seven. For services beyond the established benefit limit, extensions will may be available provided if medically necessary, following the medical necessity review process described in the state's provider manual. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited. Certain services, specified in the appropriate provider manual, are not counted toward the limit. Clients in the Child Health Services (EPSDT) Program are not benefit limited.~~

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CATEGORICALLY NEEDY

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)
- b. Optometrist Services (Continued)
- (2) One eye exam every twelve (12) months for eligible beneficiaries under twenty-one (21) years of age in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Extensions of the benefit limit will be available if medically necessary for beneficiaries in the EPSDT Program.
 - (3) Medical services provided by an optometrist are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries aged twenty-one (21) years or older. For services beyond the benefit limit, extensions may be available if medically necessary, following the medical necessity review process described in the state's provider manual. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.
- c. Chiropractor Services
- (1) Services are limited to licensed chiropractors meeting minimum standards promulgated by the Secretary of HHS under Title XVIII.
 - (2) Services are limited to treatment by means of manual manipulation of the spine which the chiropractor is legally authorized by the State to perform.
 - (3) Effective for dates of service on or after July 1, 1996, chiropractic services will be limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for eligible Medicaid beneficiaries aged twenty-one (21) years or older. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.
 - (4) Effective for dates of service on or after January 1, 2018, chiropractic services do not require a referral by the client's primary care provider (PCP).
- d. Advanced Practice Registered Nurses (APRN)
- Advanced practice registered nurses include without limitation licensed advanced practice registered nurses who hold specialized certifications such as clinical nurse specialist, certified nurse midwife, who are practicing within the scope of their APRN license according to state law.
- For beneficiaries aged twenty-one (21) years of age or older, services provided in an advanced practice registered nurse's office, a patient's home, or nursing home are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).
- For services beyond the established benefit limit, extensions may be provided if medically necessary, following the medical necessity review process described in the state's provider manual. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.

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CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by a physician assistant are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

For services beyond the established benefit limit, extensions may be provided if medically necessary following the medical necessity review process described in the state's provider manual.

Beneficiaries eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are not benefit-limited.

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CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by a physician assistant are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

For services beyond the established benefit limit, extensions may be provided if medically necessary following the medical necessity review process described in the state's provider manual.

Beneficiaries eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are not benefit-limited.

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CATEGORICALLY NEEDY

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

- (11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

(12) Physician Assistant

Refer to Attachment 3.1-A, Page 2e1, Section 6, Item e.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

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CATEGORICALLY NEEDY

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

- (11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

- (12) Physician Assistant

Refer to Attachment 3.1-A, Page 2e1, Section 6, Item e.

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Page 7d

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Revised: August

CATEGORICALLY NEEDY

17. Nurse–Midwife Services

~~Nurse midwives must be licensed as Advanced practice registered nurses with specialized certification as certified nurse midwives, who are practicing within the scope of their APRN license according to state law. Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse midwife. A certified nurse midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.~~

~~Services provided by a certified nurse midwife are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, office medical services furnished by an optometrist and advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries under age 21 in the Child Health Services (EPSDT) program are not benefit limited.~~

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Revised: July 1, 2026

17. Nurse Midwife Services

Nurse midwives must be licensed as Advanced practice registered nurses with specialized certification as certified nurse midwives, who are practicing within the scope of their APRN license according to state law.

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AMOUNT, DURATION, AND SCOPE OF
SERVICES PROVIDED

Revised: ~~October 1,~~
2023 July 1, 2026

MEDICALLY NEEDY

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30. ~~Outpatient hospital services include the following:~~

- ~~• non-emergency outpatient hospital and related physician and nurse practitioner services; and~~
- ~~• outpatient hospital therapy and treatment services and related physician and nurse practitioner services.~~

For services beyond the 12-visit limit, an extension of benefits ~~will~~may be provided ~~if medically necessary following the medical necessity review process described in the state's provider manual. The following diagnoses are considered categorically medically necessary and do not require prior authorization for medical necessity: Malignant neoplasm; HIV infection; renal failure; opioid use disorder when the visit is part of a Medication Assisted Treatment plan, and pregnancy. All other diagnoses are subject to prior authorization before benefits can be extended.~~

Outpatient hospital services are not benefit limited for ~~recipients in the Child Health Services~~beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)- ~~Program~~services.

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MEDICALLY NEEDY

2.a. Outpatient Hospital Services (Continued)

Non-Emergency Services

Outpatient hospital services other than those which qualify as emergency, outpatient surgical procedures and treatment, and therapy services are covered as non-emergency services.

Benefit Limit

Outpatient hospital services are limited to a total of twelve (12) visits a year. This yearly limit is based on the State Fiscal Year - July 1 through June 30.

For services beyond the 12-visit limit, an extension of benefits may be provided following the medical necessity review process described in the state's provider manual.

Outpatient hospital services are not benefit limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

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MEDICALLY NEEDY

2.b. Rural Health Clinic (RHC) Services

Rural ~~health clinic~~ Health Clinic (RHC) services are limited to sixteen (16) ~~visits~~ encounters a year for ~~clients~~ beneficiaries twenty-one (21) years of age and ~~or~~ older. This yearly limit is based on the State Fiscal Year (July 1 through June 30).

~~Rural health clinic encounters will be considered in conjunction with the benefit limit established for physician services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, federally qualified health center encounters, and advanced practice registered nurse services, or a combination of the seven. Benefit limit extensions will be available if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the service limit. Clients under age twenty-one (21) in the Child Health Services-Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program services are not benefit-limited.~~

RHC services include Medicare core services and any other ambulatory service included in the state plan if the RHC offers such a service (e.g. dental, optometrist, etc.). The "other ambulatory services" provided by the RHC will count against the limit established in the plan for the covered service. For services beyond the benefit limit, an extension of benefits may be provided following the medical review process described in the state's provider manual pertinent to the particular service.

~~Rural health clinic core services are defined as follows:~~

- ~~1. Physicians' services, advanced practice registered nurses' services, and services of physician assistants when provided under proper supervision;~~
- ~~2. Services and supplies furnished as an incident to professional services;~~

~~Services and supplies "incident to" the professional services of physicians, physician assistants, or advanced practice registered nurses, are those which are commonly furnished in connection with these professional services, are generally furnished in the rural health clinic office, and are ordinarily rendered without charge or included in the clinic's bills; e.g., laboratory services, ordinary medications and other services and supplies used in patient primary care services.~~

- ~~3. Clinical psychologist services;~~
- ~~4. Clinical social worker services;~~

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SERVICES PROVIDED**

Revised: July 1, 2026

MEDICALLY NEEDY

2.b. Rural Health Clinic (RHC) Services

Rural Health Clinic (RHC) services are limited to sixteen (16) encounters a year for beneficiaries twenty-one (21) years of age and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30).

Benefit limit extensions are available if medically necessary. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.

RHC services include Medicare core services and any other ambulatory service included in the state plan if the RHC offers such a service (e.g. dental, optometrist, etc.). The “other ambulatory services” provided by the RHC will count against the limit established in the plan for the covered service. For services beyond the benefit limit, an extension of benefits may be provided following the medical review process described in the state’s provider manual pertinent to the particular service.

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Revised: October 1, 2023 July 1, 2026

MEDICALLY NEEDY

2.b. Rural Health Clinic Services

~~5. Services of nurse midwives; and~~

~~6. Visiting nurse services on a part-time or intermittent basis to home-bound patients (limited to areas in which there is a shortage of home health agencies).~~

~~Rural health clinic ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the rural health clinic offers such a service (e.g. dental, visual, etc.). The “other ambulatory services” that are provided by the rural health clinic will count against the limit established in the plan for that service.~~

~~Medication Assisted Treatment visits do not count against the Rural Health Clinic encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.~~

2.c. Federally Qualified Health Center (FQHC) Services

Federally qualified health center (FQHC) services and other ambulatory services ~~that~~ are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual) (NCFA – Pub. 45-4).

FQHC services include Medicare core services and any other ambulatory services included in the state plan if the FQHC offers such a service (e.g. dental, etc.).

~~Federally qualified health center FQHC core services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for clients-beneficiaries twenty-one (21) years of age or older. The applicable benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwife services, rural health clinic encounters, and advanced practice registered nurse services, or a combination of the seven.~~

~~Benefit extensions will be~~ Extensions of the benefit limit are available if medically necessary. ~~Clients under age twenty-one (21) in the Child Health Services-Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program-services~~ are not benefit-limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

~~Medication Assisted Treatment visits do not count against the FQHC encounter benefit limit when the diagnosis is for opioid use disorder and is part of a Medication Assisted Treatment plan.~~

The “other ambulatory services” provided by the FQHC will count against the limit established in the plan for that service. For services beyond the benefit limit for those services, an extension of benefits may be provided following the medical necessity review process described in the state’s provider manual.

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Revised:

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2.c. Federally Qualified Health Center (FQHC) Services

Federally qualified health center (FQHC) services and other ambulatory services are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (NCFA – Pub. 45-4).

FQHC services include Medicare core services and any other ambulatory services included in the state plan if the FQHC offers such a service (e.g. dental, etc.).

FQHC core services are limited to sixteen (16) encounters per client, per State Fiscal Year (July 1 through June 30) for beneficiaries twenty-one (21) years of age or older.

Extensions of the benefit limit are available if medically necessary. Beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are not benefit-limited.

FQHC hospital visits are limited to one (1) day of care for inpatient hospital covered days regardless of the number of hospital visits rendered. The hospital visits do not count against the FQHC encounter benefit limit.

The “other ambulatory services” provided by the FQHC will count against the limit established in the plan for that service. For services beyond the benefit limit for those services, an extension of benefits may be provided following the medical necessity review process described in the state’s provider manual.

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Revised: January 1, 2022July 1,

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~~2.c. Federally Qualified Health Center (FQHC) services and other ambulatory services that are covered under the plan and furnished by a FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4). (Continued)~~

~~Covered FQHC core services are defined as follows:~~

- ~~• physician services;~~
- ~~• services and supplies incident to physician's services (including drugs and biologicals that cannot be self-administered);~~
- ~~• pneumococcal vaccine and its administration and influenza vaccine and its administration;~~
- ~~• physician assistant services;~~
- ~~• nurse practitioner services;~~
- ~~• clinical psychologist services;~~
- ~~• clinical social worker services;~~
- ~~• licensed certified social worker services;~~
- ~~• licensed professional counselor services;~~
- ~~• licensed mental health counselor services;~~
- ~~• licensed marriage and family therapist services;~~
- ~~• services and supplies incident to clinical psychologist, clinical social worker services, licensed certified social worker, licensed professional counselor, licensed mental health counselor and licensed marriage and family therapist services as would otherwise be covered if furnished by or incident to physician services; and~~
- ~~• part time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area in which the Secretary has determined there is a shortage of home health agencies.~~

~~FQHC ambulatory services are defined as any other ambulatory service included in the Medicaid State Plan if the FQHC offers such a service, (e.g. dental, etc.). The "other ambulatory services" that are provided by the FQHC will count against the limit established in the plan for that service.~~

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2eee

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised:

July 1, 2026

MEDICALLY NEEDY

RESERVED

PROPOSED

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 2xxxx

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

MEDICALLY NEEDY

Revised: July 1, 2022-2026

5. a. Physicians' Services

Physician Services are furnished by a physician within the scope of practice of medicine or osteopathy as defined by State law; and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Physician's services For clients twenty-one (21) years of age or older, services provided in a physician's office, a patient's beneficiary's home, a hospital, a skilled nursing facility, or nursing home or elsewhere are limited to sixteen (16) visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age or older.

For services beyond the established visit limit, extensions will be available following the medical necessity review process described in the state's provider manual.

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurses services, Rural Health Clinics rural health clinic, medical services furnished by a dentist, office medical services furnished by an optometrist, certified nurse midwives midwife services, physician assistants, clinical nurse specialists, and federally qualified health center Federally Qualified Health Centers, or a any combination thereof the seven.

For services beyond the established visit limit, extensions will be available if medically necessary. Clients in the Child Health Services Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program services are not benefit limited.

(1) The following diagnoses are considered categorically medically necessary and are exempt from benefit extension requirements: Malignant neoplasm; HIV infection and renal failure.

(2) Physicians' visits for pregnancy in the outpatient hospital are exempt from benefit extension requirements.

(3) Each attending physician or dentist is limited to billing one day of care for inpatient hospital covered days regardless of the number of hospital visits rendered.

(4) Surgical procedures which are generally considered to be elective require prior authorization from the Utilization Review Section.

(5) Desensitization injections Refer to Attachment 3.1 A, Item 4.b. (12).

(6) Organ transplants are covered as described in Attachment 3.1 E.

(7) Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, advanced practice registered nurse's office, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit described in Item 5.(1) of sixteen (16) per SFY. Extensions of the benefit limit will be available if medically necessary following the medical necessity review process described in the state's provider manual.

(8) Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act):

Medical services furnished by a dentist are limited to twelve (12) visits per State Fiscal Year (July 1 through June 30) for clients twenty-one (21) years or older.

TN: ~~22-001026-0010~~

Approved: Effective: 07/01/2022 07/01/2026

Supersedes TN: AR-18-00222-0010

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: July 1, 2026

MEDICALLY NEEDY

5. a. Physicians' Services

Physician Services are furnished by a physician within the scope of practice of medicine or osteopathy as defined by State law; and by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

Physician's services provided in the office, a beneficiary's home, a hospital, a skilled nursing facility, or elsewhere are limited to sixteen (16) visits per state fiscal year (July 1 through June 30) for beneficiaries twenty-one (21) years of age or older.

For services beyond the established visit limit, extensions will be available following the medical necessity review process described in the state's provider manual.

The benefit limit will be in conjunction with the benefit limit established for advance practice registered nurses, Rural Health Clinics, medical services furnished by dentists, medical services furnished by optometrists, certified nurse midwives, physician assistants, clinical nurse specialists, and Federally Qualified Health Centers, or any combination thereof.

Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Consultations, including interactive consultations (telemedicine), are limited to two (2) per recipient per year in a physician's office, advanced practice registered nurse's office, patient's home, hospital, or nursing home. This yearly limit is based on the State Fiscal Year (July 1 through June 30). This limit is in addition to the yearly limit of sixteen (16) per SFY. Extensions of the benefit limit will be available if medically necessary following the medical necessity review process described in the state's provider manual.

Abortions are covered when the life of the mother would be endangered if the fetus were carried to term or for victims of rape or incest. The circumstances must be certified in writing by the woman's attending physician. Prior authorization is required.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
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ATTACHMENT 3.1-B
Page 2y

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2008–July 1, 2026

MEDICALLY NEEDY

5. b. Medical and surgical services furnished by a dentist (in accordance with Section 1905 (a)(5)(B) of the Act).
(continued)

“Medical and surgical services of a dentist” means medical and surgical services furnished, by a doctor of dental medicine or dental surgery if the services are services that:

1. If furnished by a physician, would be considered physician's services.
2. Under the law of the State where they are furnished, may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
3. Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services.”

Medical services furnished by a dentist are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. Extensions of the benefit limit may be provided if medically necessary, following the medical necessity review process described in the state's provider manual.

~~The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, rural health clinic services, office medical services furnished by an optometrist, certified nurse midwife services and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the 12 visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Recipients under age 21 in the Child Health Services Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) servicesProgram are not benefit limited.~~

Surgical services furnished by a dentist are not benefit-limited.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: July 1, 2026

MEDICALLY NEEDY

5. b. Medical and surgical services furnished by a dentist in accordance with Section 1905 (a)(5)(B) of the Act.

“Medical and surgical services of a dentist” means medical and surgical services furnished, by a doctor of dental medicine or dental surgery if the services are services that:

1. If furnished by a physician, would be considered physician's services.
2. Under the law of the State where they are furnished, may be furnished either by a physician or by a doctor of dental medicine or dental surgery; and
3. Are furnished by a doctor of dental medicine or dental surgery who is authorized to furnish those services in the State in which he or she furnished the services.”

Medical services furnished by a dentist are limited to sixteen (16) visits per State Fiscal Year (July 1 through June 30) for beneficiaries twenty-one (21) years of age and older. Extensions of the benefit limit may be provided if medically necessary, following the medical necessity review process described in the state's provider manual.

Services are not benefit-limited for beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Surgical services furnished by a dentist are not benefit-limited.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

July 1, 2026

MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished
by licensed practitioners within the scope of their practice as defined by State law.
(Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by a physician
assistant are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

-For services beyond the established benefit limit, extensions may be provided if medically
necessary following the medical necessity review process described in the state's provider
manual.

Beneficiaries eligible for Early and Periodic Screening, Diagnostic and Treatment
(EPSDT) services are not benefit-limited.

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

July 1, 2026

MEDICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
(Continued)

e. Physician Assistant

For beneficiaries twenty-one (21) years of age or older, services provided by a physician assistant are limited to sixteen (16) visits per state fiscal year (July 1 through June 30).

For services beyond the established benefit limit, extensions may be provided if medically necessary following the medical necessity review process described in the state's provider manual.

Beneficiaries eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are not benefit limited.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF ARKANSAS

ATTACHMENT 3.1-B
Page 3d(1)

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED
2026

Revised: ~~April 1, 2024~~ July 1,

MEDICALLY NEEDY

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

(11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

(12) Physician Assistant

Refer to Attachment 3.1-B, Page 3b1, Section 6, Item e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
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ATTACHMENT 3.1-B
Page 3d(1)

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: July 1, 2026

MEDICALLY NEEDY

6. Medical Care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6.d. Other Practitioners' Services (Continued)

- (11) Emergency Medical Technicians who are licensed to provide advanced life support and basic life support services.

- (12) Physician Assistant

Refer to Attachment 3.1-B, Page 3b1, Section 6, Item e.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 6d

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED
2026

Revised: ~~August 1, 2008~~ — July 1,

MEDICALLY NEEDY

17. Nurse-Midwife Services

Nurse midwives must be licensed as Advanced practice registered nurses with specialized certification as certified nurse midwives, who are practicing within the scope of their APRN license according to state law.

~~Any person possessing the qualifications for a registered nurse in the State of Arkansas who is also certified as a nurse-midwife by the American College of Nurse-Midwives, upon application and payment of the requisite fees to the Arkansas State Board of Nursing, be qualified for licensure as a certified nurse-midwife. A certified nurse-midwife meeting the requirements of Arkansas Act 409 of 1995 is authorized to practice nurse-midwifery.~~

~~Services provided by a certified nurse midwife are limited to twelve (12) visits a year for beneficiaries age 21 and older. This yearly limit is based on the State Fiscal Year (July 1 through June 30). The benefit limit will be considered in conjunction with the benefit limit established for physicians' services, medical services furnished by a dentist, rural health clinic services, office medical services furnished by an optometrist and services provided by an advanced practice nurse or registered nurse practitioner or a combination of the six. For services beyond the twelve visit limit, extensions will be provided if medically necessary. Certain services, specified in the appropriate provider manual, are not counted toward the 12 visit limit. Beneficiaries under age 21 in the Child Health Services (EPSDT) program are not benefit limited.~~

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE OF ARKANSAS**

**ATTACHMENT 3.1-B
Page 6d**

**AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED**

Revised: July 1, 2026

MEDICALLY NEEDY

17. Nurse Midwife Services

Nurse midwives must be licensed as Advanced practice registered nurses with specialized certification as certified nurse midwives, who are practicing within the scope of their APRN license according to state law.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 4.19-B
Page 14

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE
2026

Revised:

August 1, 2008July 1,

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing.

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) procedure codes. Medicaid maximum allowables are is -the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the advanced practice nurse and physician.

Except as otherwise noted in the planState Plan, state developed fee schedule rates are the same for both governmental and private providers of services when provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/> @ www.medicaid.state.ar.us.

28. Physician Assistant as licensed by the Arkansas Medical Board

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except for EPSDT procedure codes. Medicaid maximum allowable is the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the physician assistant and the physician.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of services when provided by Physician Assistants. The agency's fee schedule rate was set as of July 1, 2026, and is effective for services provided on or after that date. All rates are published on the agency's website: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: July 1, 2026

27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing.

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) procedure codes. Medicaid maximum allowable is the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the advanced practice nurse and physician.

Except as otherwise noted in the State Plan, state developed fee schedule rates are the same for both governmental and private providers of services when provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

28. Physician Assistant as licensed by the Arkansas Medical Board

Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is 80% of the physician fee schedule except for EPSDT procedure codes. Medicaid maximum allowable is the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the physician assistant and the physician.

Except as otherwise noted in the State Plan, state-developed fee schedule rates are the same for both governmental and private providers of services when provided by Physician Assistants. The agency's fee schedule rate was set as of July 1, 2026, and is effective for services provided on or after that date. All rates are published on the agency's website: <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/fee-schedules/>

Citation

Condition or Requirement

 X vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

~~The State established a website (www.paymentinitiative.org) to keep the public informed during the design of the PCMH program and provide current information on progress towards implementation. The website is a 'one stop shop' for documents and information PCMH and includes an email address for interested parties to send suggestions. The State also established a toll free number manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications.~~

~~The PCMH Provider Manual explaining the program in detail is posted on the website. Webinars on program overview, enrollment process, benefits and requirements are also posted on the website along with FAQs on relevant topics.~~

~~There is a statewide promulgation process including a 30 day public comment period, after which feedback is incorporated into the version that is submitted for State legislative approval.~~

The State established a website as a 'one stop shop' for PCMH documents and information and includes multiple contacts where stakeholders can send suggestions. The State also established multiple contact numbers manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications. The PCMH Provider Manual explaining the program in detail is posted on the website at:

(<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/patient-centered-medical-home/>)

Webinars on PCMH updates are also posted on a provider relations website (<https://medicaid.afmc.org/provider-relations-policy-education/webinars>).

State: Arkansas

Date Received: 24 October, 2018

Date Approved: 28 February, 2019

Effective Date: 1 January, 2019

Transmittal Number: 18-0013

TN: ~~18-001326-~~
0010

Supersedes TN: ~~13-~~
002618-
0013

Approved: ~~02/28/2019~~
01/01/201907/01/2026

Effective:

MARK-UP

State: ARKANSAS

Citation	Condition or Requirement
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 X .vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented.

The State established a website as a ‘one stop shop’ for PCMH documents and information and includes multiple contacts where stakeholders can send suggestions. The State also established multiple contact numbers manned by service representatives to answer public/provider questions on PCMH program. These service representatives triage and escalate as needed, and catalogue questions for changes to the technical design, operational processes, or communications. The PCMH Provider Manual explaining the program in detail is posted on the website at:

(<https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/patient-centered-medical-home/>)

Webinars on PCMH updates are also posted on a provider relations website (<https://medicaid.afmc.org/provider-relations-policy-education/webinars>).

State of Arkansas

As Engrossed: S2/25/25

95th General Assembly

A Bill

Regular Session, 2025

SENATE BILL 100

By: Senator C. Penzo

By: Representatives Gramlich, Springer

For An Act To Be Entitled

AN ACT TO AUTHORIZE THE ARKANSAS MEDICAID PROGRAM TO
RECOGNIZE A PHYSICIAN ASSISTANT AS A PRIMARY CARE
PROVIDER; AND FOR OTHER PURPOSES.

Subtitle

TO AUTHORIZE THE ARKANSAS MEDICAID
PROGRAM TO RECOGNIZE A PHYSICIAN
ASSISTANT AS A PRIMARY CARE PROVIDER.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is
amended to add an additional section to read as follows:

20-77-154. Primary care provider for Arkansas Medicaid Program –
Physician assistant.

(a) If authorized by a physician assistant's supervising physician,
the Arkansas Medicaid Program shall recognize a physician assistant licensed
by the Arkansas State Medical Board as a primary care provider authorized to
carry out the following duties of a primary care case manager:

(1) Being recognized and serving as the initial healthcare
provider in the program; and

(2) Treating a patient within the scope of practice and
licensure of a physician assistant under § 17-105-107.

(b) The program shall reimburse a physician assistant:

(1) Not less than the current reimbursement rate for services
performed within the scope of practice and licensure of the physician
assistant; and



1 (2) One hundred percent (100%) of the physician reimbursement
2 rate for all out-of-pocket costs incurred by the physician assistant such as
3 the costs of laboratory tests, X-rays, and any additional tests ordered or
4 conducted by the physician assistant.

5 (c) A healthcare insurance policy in which the premiums are paid
6 directly or indirectly by the program also shall recognize and reimburse a
7 physician assistant under subsections (a) and (b) of this section.

8 (d) This section does not increase the scope of practice or licensure
9 of a physician assistant.

10 (e) When initially applying to the program to be recognized as a
11 primary care provider and case manager under this section, a physician
12 assistant shall provide a written authorization that is signed and dated by
13 his or her supervising physician.

14
15 /s/C. Penzo
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18 **APPROVED: 4/8/25**
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