QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.

MMIS Annual Billing Conference Spring 2024

Karen Young
Training and Program Developer, MMIS, AFMC

John Selig, MPA

President and CEO, AFMC

MMIS Outreach Team

MMIS OUTREACH SPECIALISTS

HOURS OF OPERATION:
Monday–Friday • 8 A.M.–5 P.M.

MMIS Manager

Becky Andrews 501-212-8738
bandrews@afmc.org

MMIS Supervisor

Andrea Allen
Pulaski County ....501-906-7566 Ex. 1
pulaskibilling@afmc.org

Outreach Specialists

Christy Owens
NW—Northwest .....501-906-7566 Ex. 2-2
northwestbilling@afmc.org

Rose Bruton
NE—Northeast.....501-906-7566 Ext. 2-1
northeastbilling@afmc.org

Mary Riley
EC—East Central.....501-906-7566 Ext. 4-1
eastcentralbilling@afmc.org

Kristie Williams
SE—Southeast.....501-906-7566 Ext. 3-1
southeastbilling@afmc.org

Angie Riggan
SW—Southwest.....501-906-7566 Ext. 3-2
southwestbilling@afmc.org

Renee Smith
WC—West Central.....501-906-7566 Ext. 5-1
westcentralbilling@afmc.org

Poll Question

How many visits can a professional provider perform in an Arkansas Medicaid fiscal year without an extension of benefits?

10 visits	5 visits	16 visits	12 visits

Poll Question

Should you have specific questions concerning a requested prior authorization from AFMC such as denial, incorrect information submitted on request, etc. who would you contact?

Provider Relations	MMIS Outreach Specialist	Gainwell Provider Assistance Center	Clinical Services

Poll Question

When logged into the Arkansas Medicaid Healthcare Portal under the Billing Group Provider ID, choose the option to review all providers affiliated, or linked, with the billing group.

My profile link	Manage accounts link	Characteristics link

Poll Question

Manual updates are highlighted in what color?		
Red	Orange	Yellow

Poll Question

Which tab on the Arkansas Medicaid Healthcare portal would you upload documents to Provider Enrollment?			
Case Management Tab	Files Exchange Tab	Claims Tab	Provider Functions Tab

MMIS Outreach Team Map

MMIS Outreach Specialists Information Sheet

ARKANSAS DEPARTMENT OF HUMAN SERVICES · gainwell · afmc

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • afmc.org/mmis

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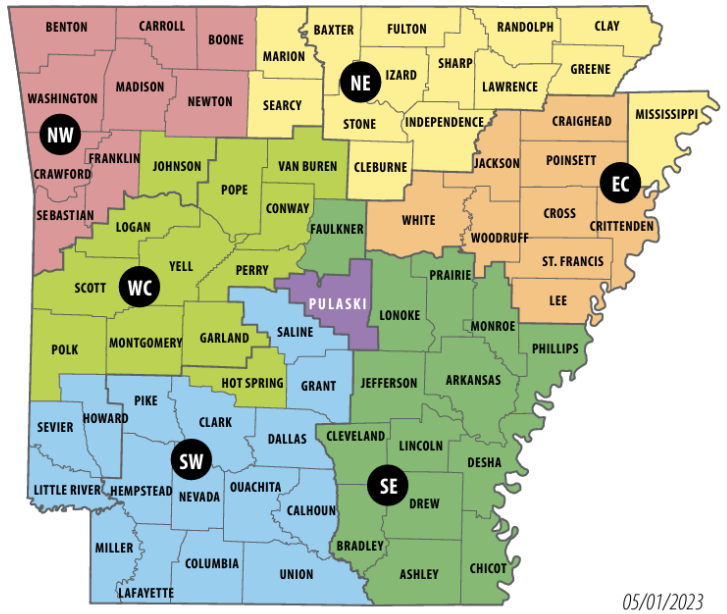


05/01/2023

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DMS

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

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

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)
Central Arkansas.....**501-682-8349**

ARKANSAS MEDICAID MANAGED CARE VOICE INFORMATION SERVICES
Toll free.....**800-805-1512**

PHARMACY
Magellan Medicaid Administration
Help Desk **800-424-7895**

TPL INFORMATION
Local **501-537-1070**
Fax.....**501-682-1644**
DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

GAINWELL TECHNOLOGIES *(Claims Processing)*

Gainwell Provider Assistance Center
In-state toll free **800-457-4454**
Local and out-of-state **501-376-2211**

Gainwell Provider Services Manager
Tyler Brickey.....**501-590-6325**

CLAIMS
P.O. Box 8034
Little Rock, AR 72203

SPECIAL CLAIMS
ATTN: Research Analysts
P.O. Box 8036
Little Rock, AR 72203

CROSSOVER CLAIMS
P.O. Box 34440
Little Rock, AR 72203

PROVIDER ENROLLMENT
P.O. Box 8105
Little Rock, AR 72203
Fax: 501-374-0746

Did You Know? Agenda

Provider Information
- Maintain current contact information

Third Party Liability (TPL)
- Coordination of Benefits policy enforcement

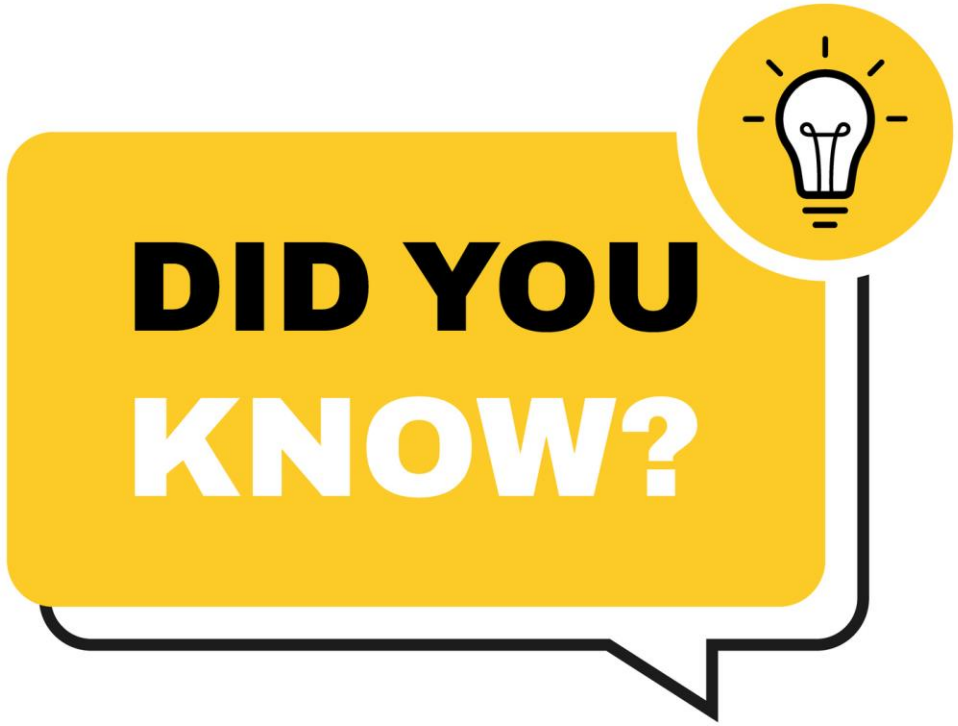
Ordering, Referring, and Prescribing
- CMS Directive

Medicare Advantage Plan
- Medicare EOMB attachment enforcement

New Medicare Crossover Form
- Professional and Inpatient

Timely Filing
- What is Timely Filing?

Things to Know
- Medicare Crossover Claims (DMS-600) coming soon!
  - New Provider Workshop
  - Medicaid 101 webinar


DID YOU
KNOW?

Provider Contact Information

Provider Contact Information

Messages for Remittance Advices dated December 7, 2023 – December 14, 2023

TO: ALL PROVIDERS RE: IMPORTANCE OF MAINTAINING CURRENT CONTACT INFORMATION WITH DHS

For general business purposes, it is important that DHS can contact providers. Please note, it is the provider's responsibility to update their contact information with DHS. This may be done via the provider portal. Contact information includes mailing, billing, service location, and email addresses. Failure to update provider information may result in delay of business processes.

A provider remains subject to audit and recoupment when appropriate, even when their contact information is not up to date. Please remember to review provider demographic information via the portal periodically, and make changes as needed.

Third-Party Liability |Coordination of Benefits

Coordination of Benefits

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

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

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

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

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

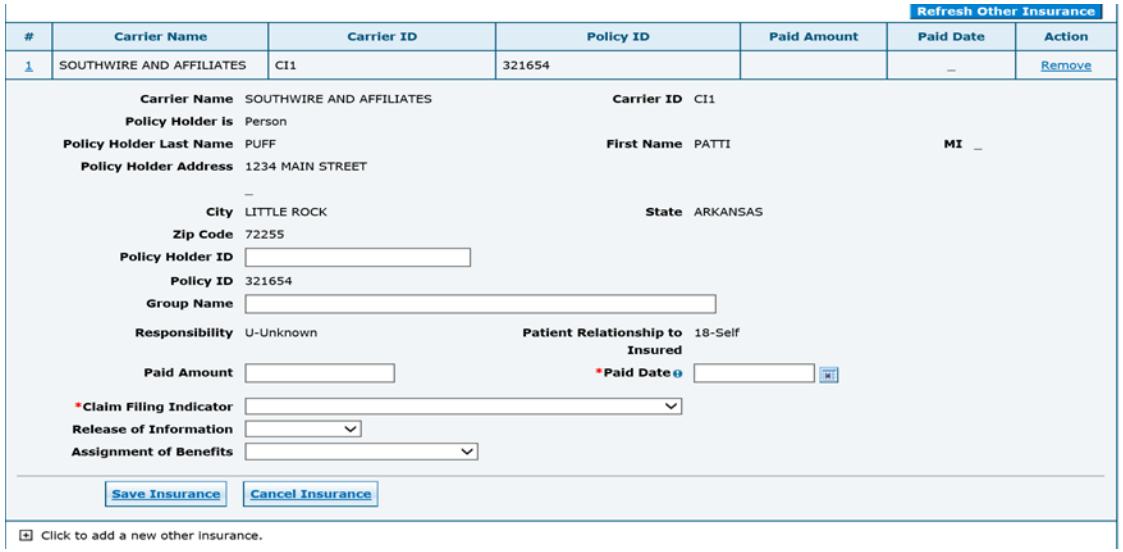
Reference: Centers for Medicare and Medicaid Services (CMS) (2020); Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid 2020; Retrieved 2/1/2024 URL: https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf

TPL Documentation/Billing Guidelines

If you are a provider of services to a Medicaid-eligible member, but the services you provide are not covered by the member's primary insurance company, please see below for documentation and billing guidelines:

- A provider can use either a Certificate of Benefits or a denial letter from insurance company (EOB with no payment to provider) or a payment to the provider (EOB with payment). They will need to keep this in the client file for auditing purposes.
- It will be good for one year for either the Certificate of Benefits or Denial EOB.
- Example: Get certificate or denial dated 01/01/2024. The provider could use it through 12/31/2024. They would say "yes" they billed the insurance using a denial date of, in this example, 01/01/2024 and $0.00 payment amount. Be sure to include Claim Filing Indicator.

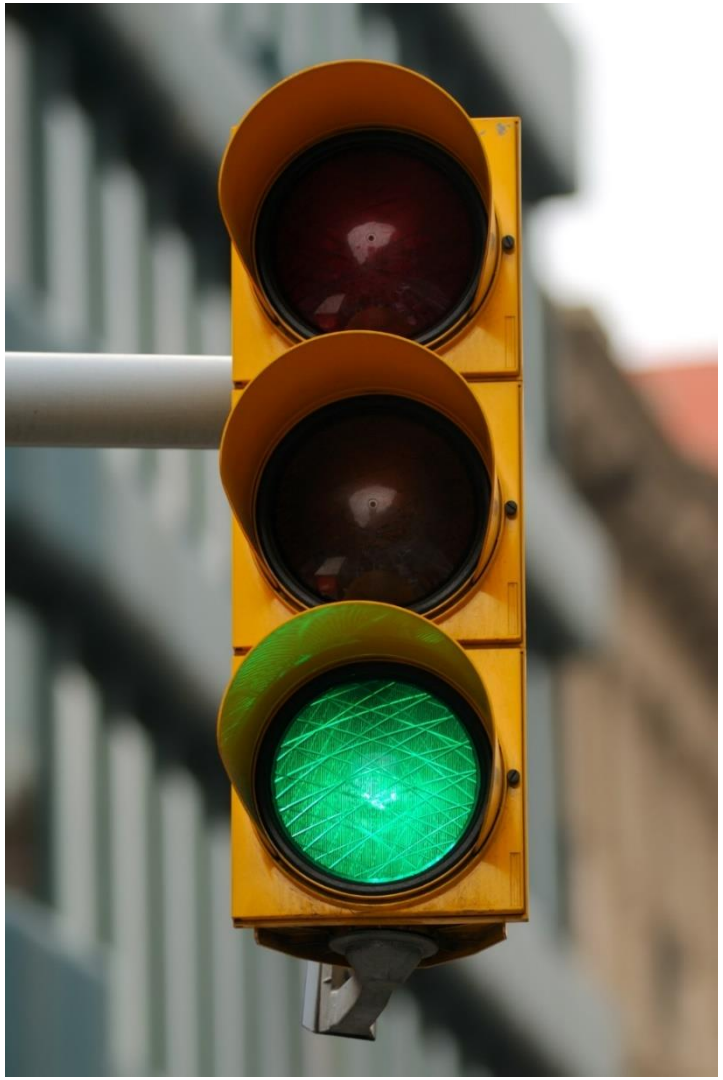
Submitting a Third-Party Liability (TPL) Claim on the Portal



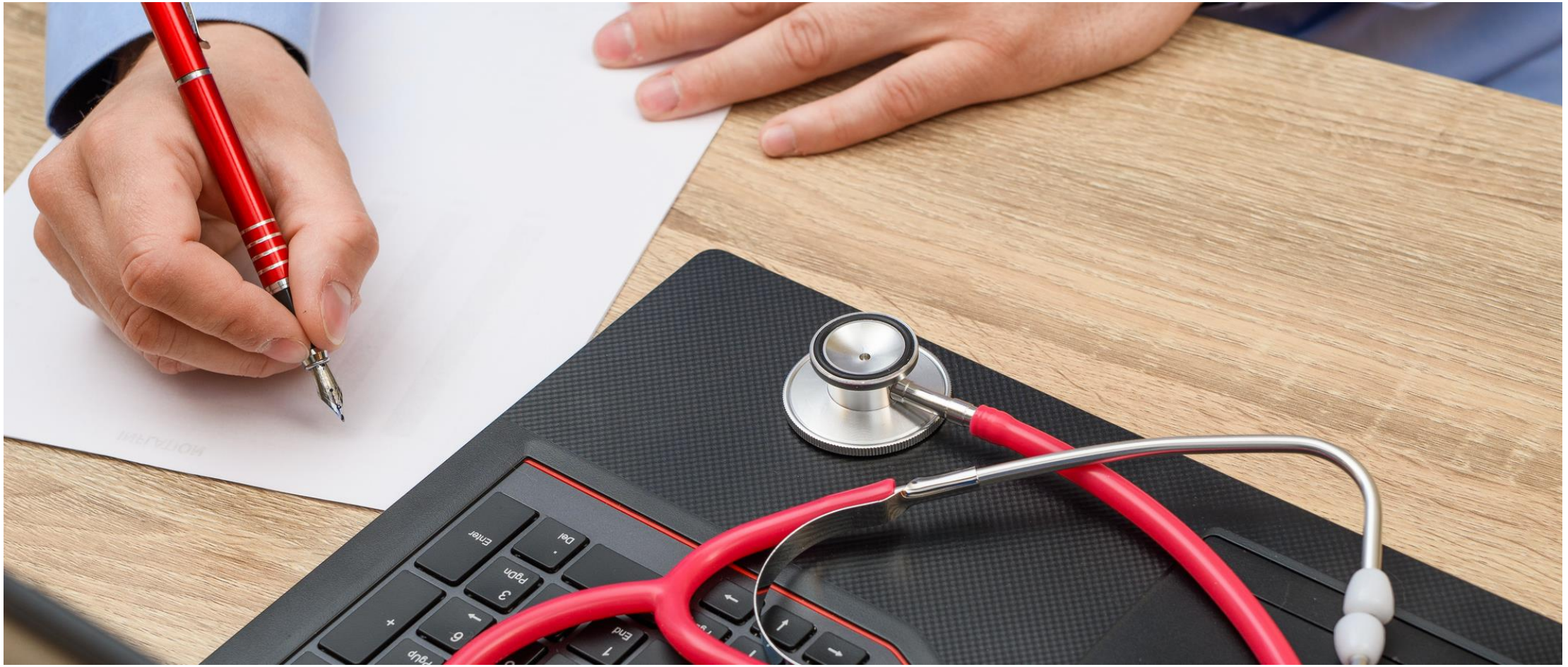
Claims

Provider Numbers

- Nine-digit provider ID
- National provider ID (NPI)
- Atypical providers (NPI not required)



Ordering, Referring, and Prescribing



Definition of Ordering, Referring, and Prescribing

Ordering — The Ordering Provider is the individual who requested the services or items being reported on this service line.

Referring — The Referring Provider is the Primary Care Provider (PCP) of a client. Please note, the PCP can also be the person who orders a service for a client but the ordering and referring do not have to be the same.

Prescribing — The Prescribing Provider is the individual who advised and authorized the use of a medicine or treatment for someone, especially in writing.

Completion of Claim Form

Professional (1500)

The following are examples of providers who would complete a CMS 1500 form:

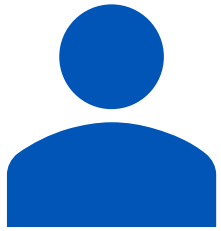
- Physicians/Other practitioners
- Transportation providers
- Vision providers
- Surgeons
- Supply providers
- HCBS/Waiver providers

Institutional (UB-04)

The following are examples of providers who would complete a UB-04 form:

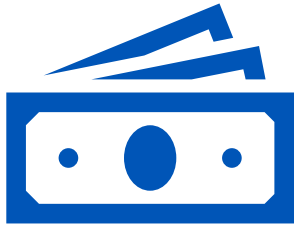
- Inpatient/Outpatient hospital
- Nursing facility
- Home health/PDN
- Hospice
- Dialysis center
- Residential treatment center
- Rural health clinics

Rendering Versus Billing Provider Professional Claim (CMS 1500)



Rendering Provider (Individual within a Group)

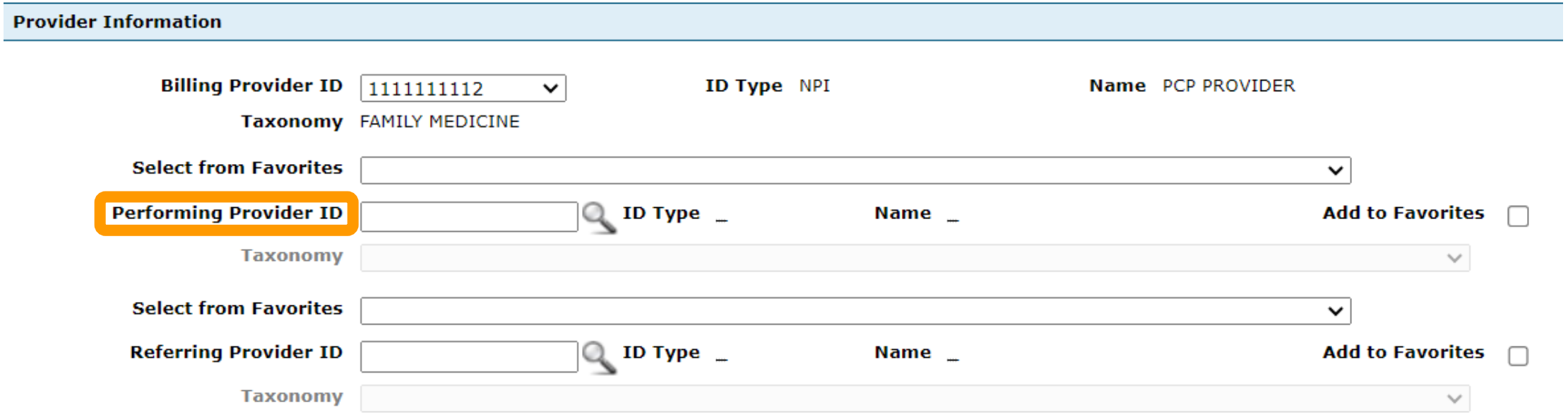
Individual who performs services for an Arkansas Medicaid client



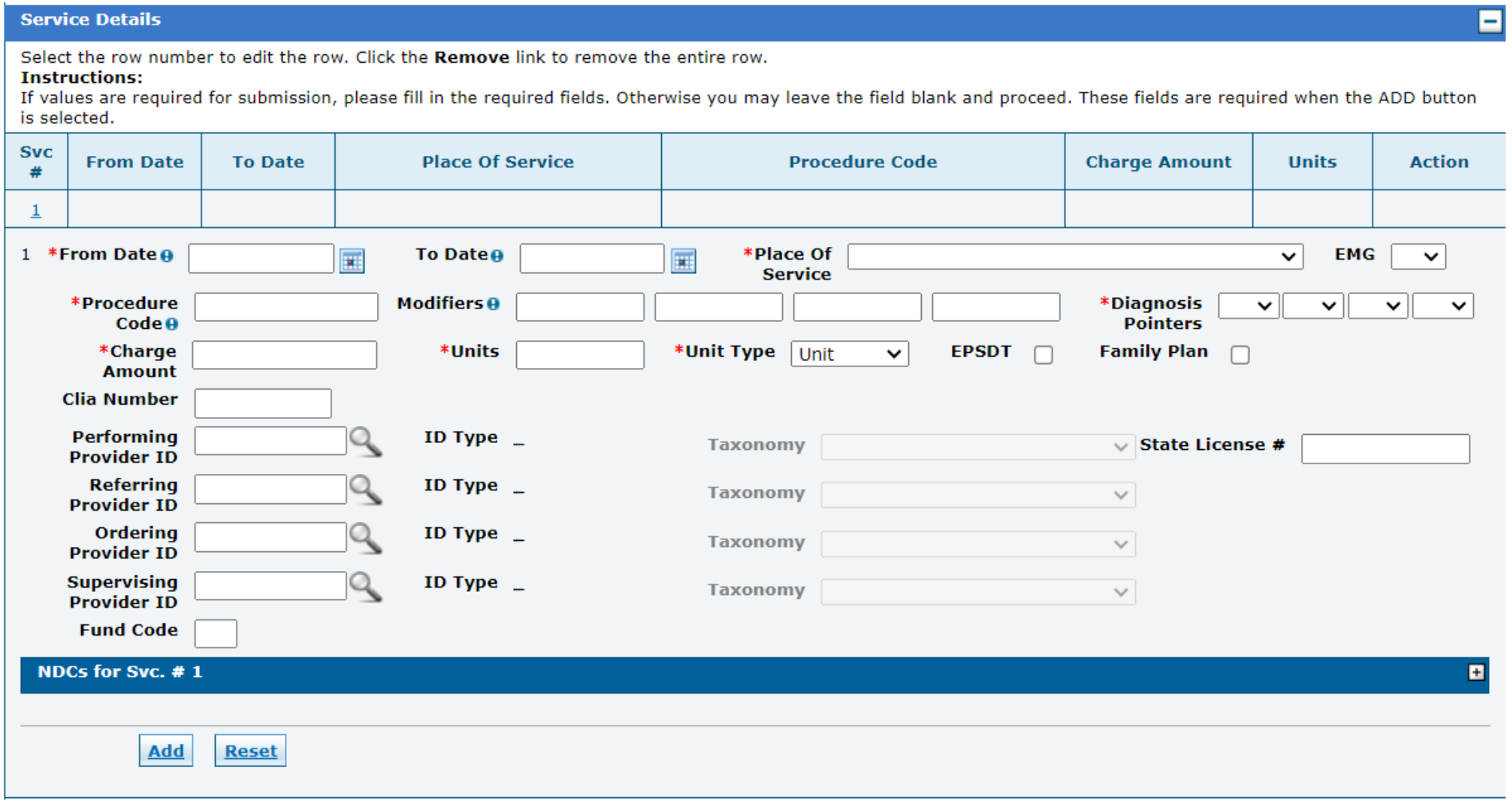
Billing Provider

Entity billing and receiving payment for service

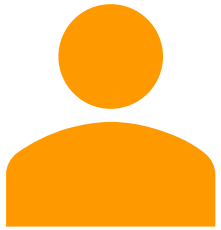
Sample of the Professional Claim



Institutional Claim Form

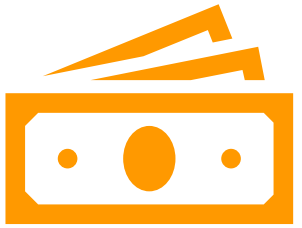


Attending Versus Billing Provider Institutional Claim (CMS 1450 or UB-04)



Attending Provider

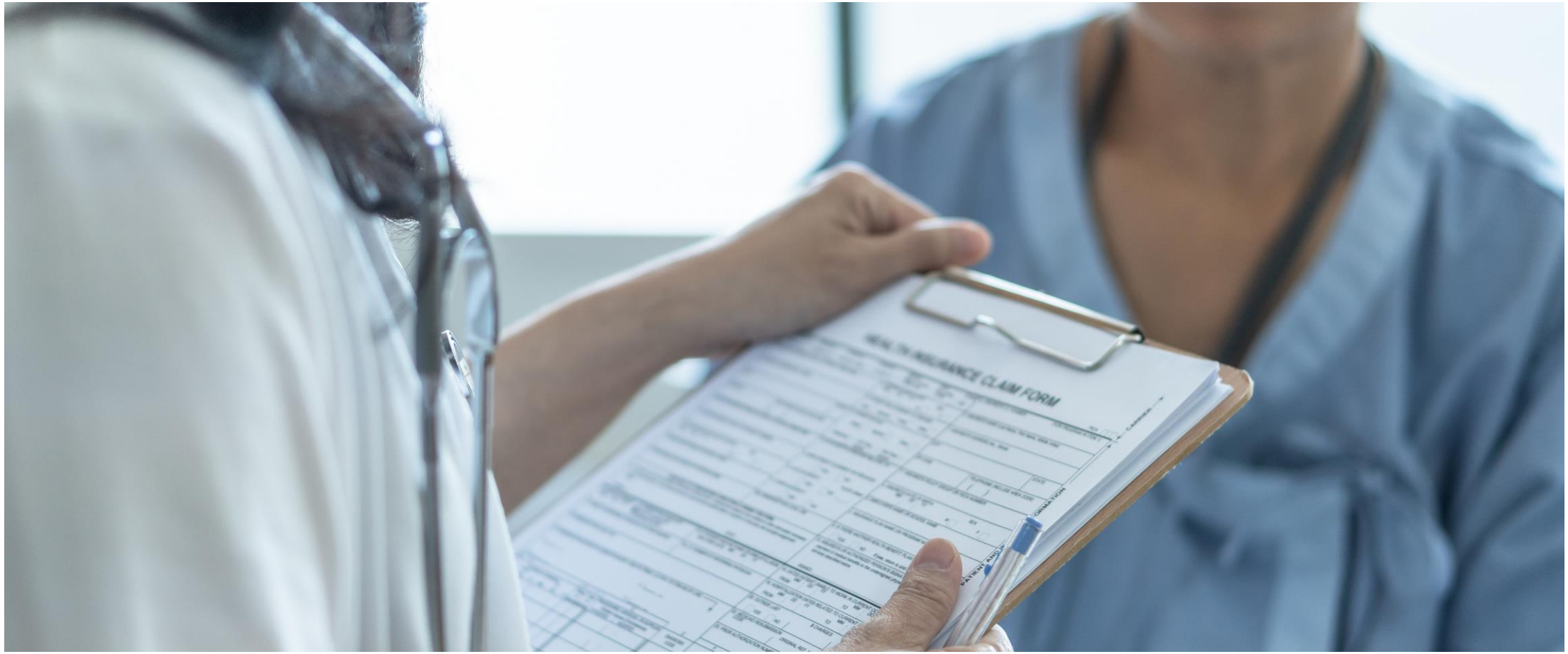
Individual who performs services for an Arkansas Medicaid client



Billing Provider

Entity billing and receiving payment for service

Medicare Advantage Plans



Medicare Advantage Plans Claims

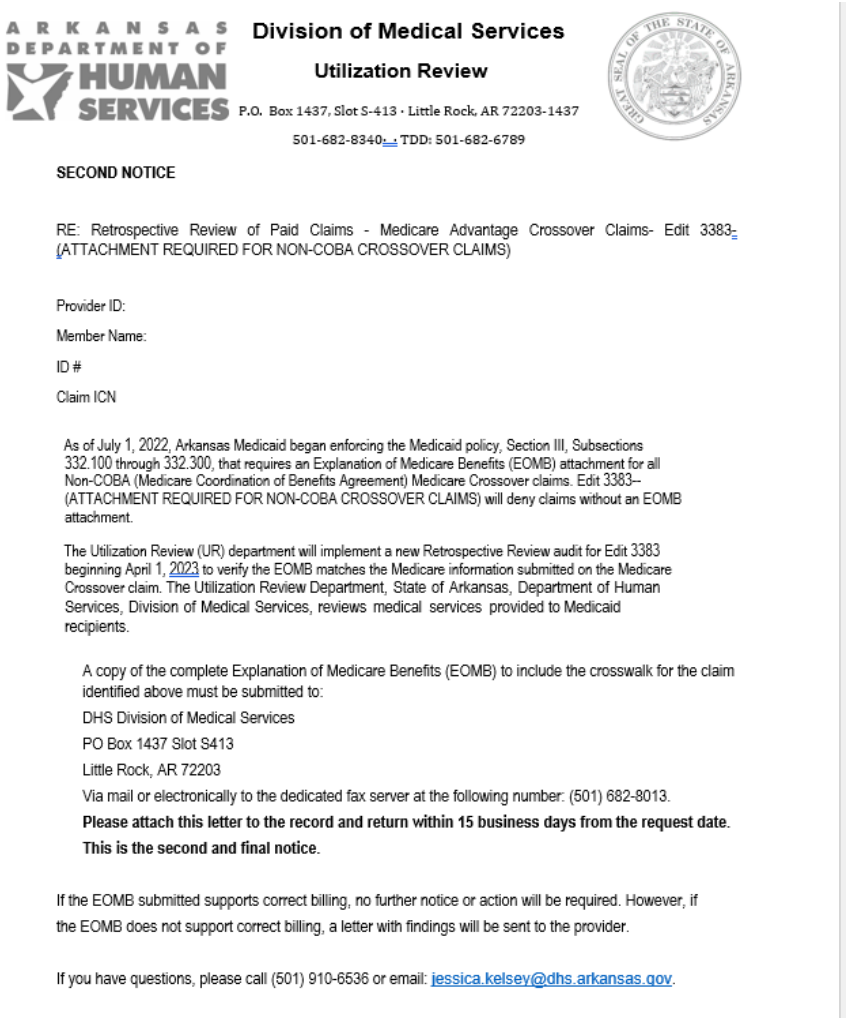
These claims do not automatically crossover to Medicaid.

- First notice
- Second notice
- Findings Letter

Retrospective review audit of Edit 3383 — (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS). Providers have received letters for paid claims requesting the required Explanation of Medicare Benefits (EOMB). Providers should disregard any Edit 3383 Retrospective Review EOMB request if the claim reviewed is a COBA claim. Please continue to submit your EOMB for Non-COBA claims as requested.

If you have questions, please contact Utilization Review Department at 501-910-6536.

Medicare Advantage Sample Letter



ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Utilization Review

P.O. Box 1437, Slot S-413 · Little Rock, AR 72203-1437

501-682-8340 · TDD: 501-682-6789

SECOND NOTICE

RE: Retrospective Review of Paid Claims - Medicare Advantage Crossover Claims- Edit 3383- (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS)

Provider ID:

Member Name:

ID #

Claim ICN

As of July 1, 2022, Arkansas Medicaid began enforcing the Medicaid policy, Section III, Subsections 332.100 through 332.300, that requires an Explanation of Medicare Benefits (EOMB) attachment for all Non-COBA (Medicare Coordination of Benefits Agreement) Medicare Crossover claims. Edit 3383-- (ATTACHMENT REQUIRED FOR NON-COBA CROSSOVER CLAIMS) will deny claims without an EOMB attachment.

The Utilization Review (UR) department will implement a new Retrospective Review audit for Edit 3383 beginning April 1, 2023 to verify the EOMB matches the Medicare information submitted on the Medicare Crossover claim. The Utilization Review Department, State of Arkansas, Department of Human Services, Division of Medical Services, reviews medical services provided to Medicaid recipients.

A copy of the complete Explanation of Medicare Benefits (EOMB) to include the crosswalk for the claim identified above must be submitted to:

DHS Division of Medical Services

PO Box 1437 Slot S413

Little Rock, AR 72203

Via mail or electronically to the dedicated fax server at the following number: (501) 682-8013.

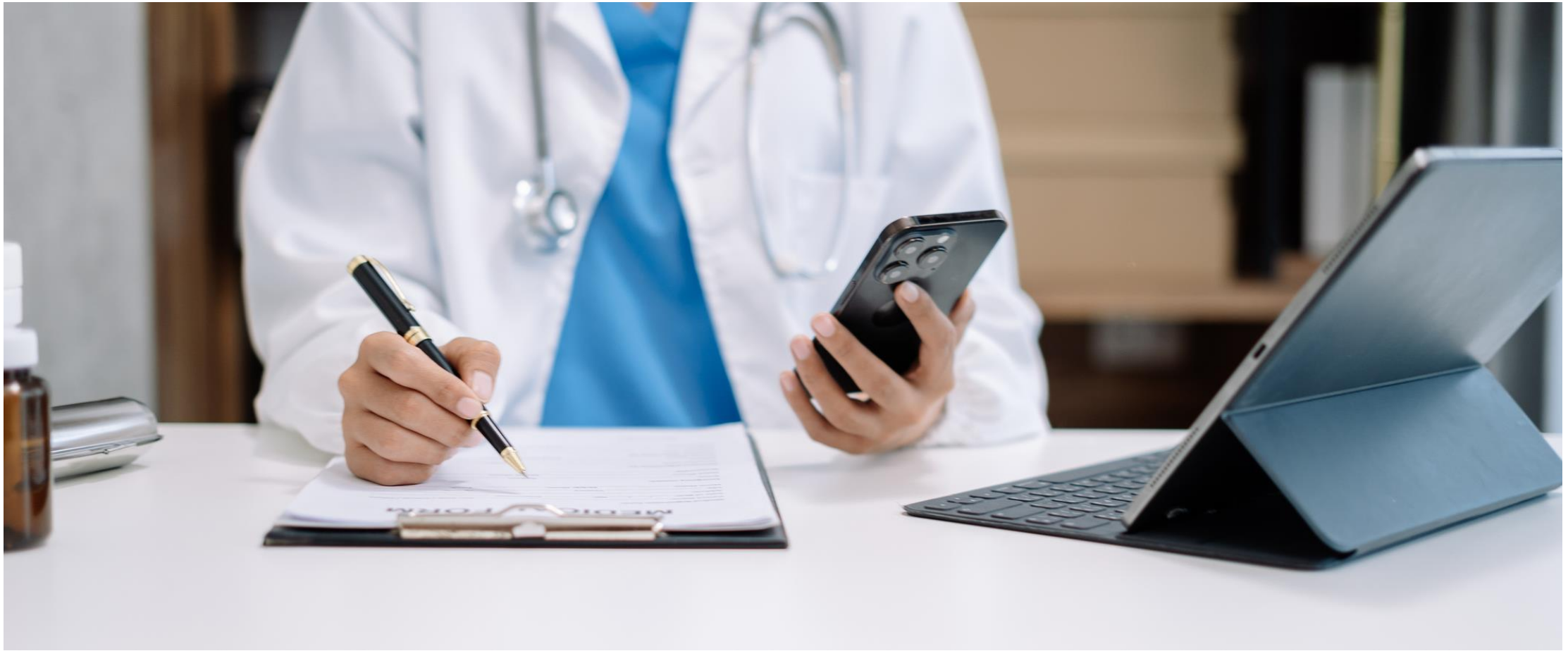
Please attach this letter to the record and return within 15 business days from the request date.

This is the second and final notice.

If the EOMB submitted supports correct billing, no further notice or action will be required. However, if the EOMB does not support correct billing, a letter with findings will be sent to the provider.

If you have questions, please call (501) 910-6536 or email: jessica.kelsey@dhs.arkansas.gov.

Timely Filing



What is Timely Filing?

Section 302.000 of the AR Medicaid manual defines timely claims. The Code of Federal Regulations states, “The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.”

The 12-month (365 days) filing deadline applies to all claims, including:

- Claims for services provided to clients with joint Medicare/Medicaid eligibility
- Adjustment requests and resubmissions of claims previously considered
- Claims for services provided to individuals who acquire Medicaid eligibility retroactively

There are no exceptions to the 12-month filing deadline policy. The definitions and additional federal regulations in Section 3 will permit flexibility for those who adhere closely to them. All providers must submit claims within the 12-month (365 days) filing deadline to meet the timely filing policy.

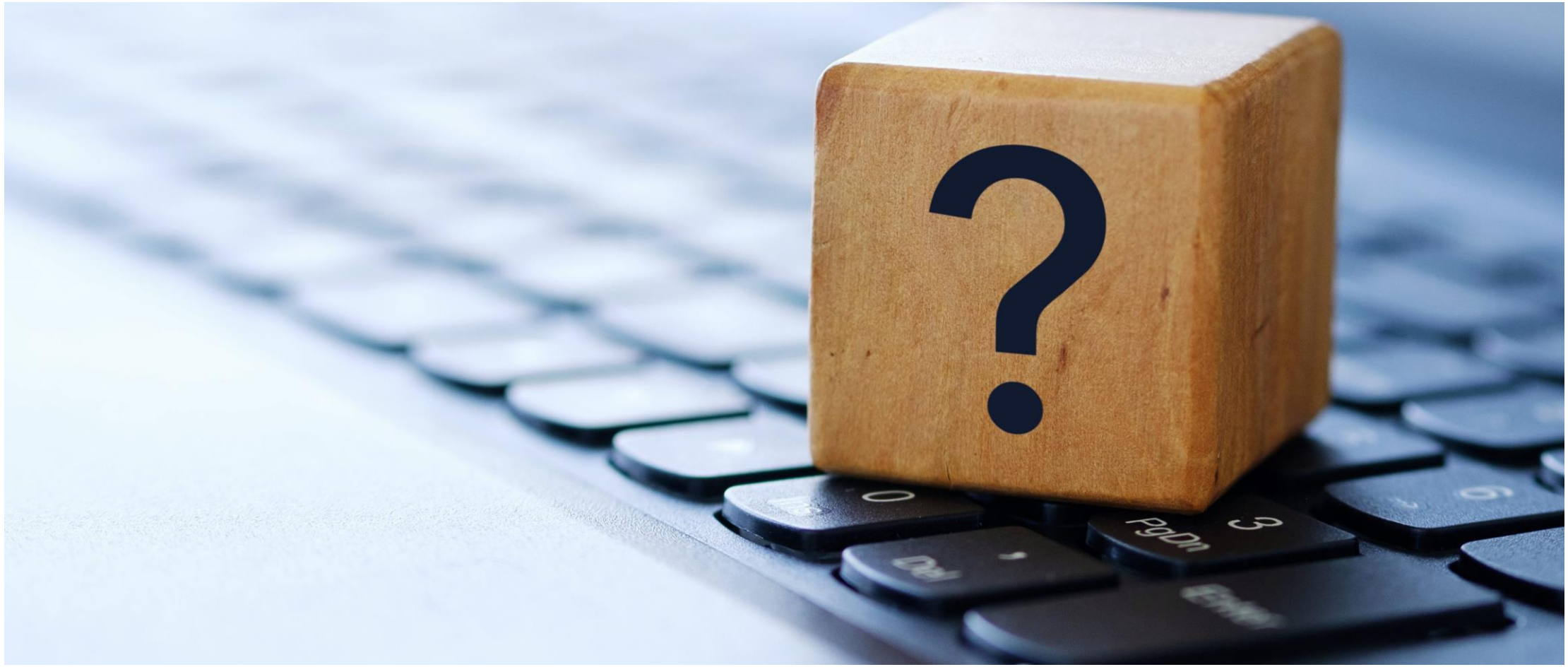
Things to Know

- *New Crossover Claim Forms(DMS - 600) are coming soon!*
- Essential Health Benefits
- New Provider Workshops every quarter (In-Person)
- MyARMedicaid App
- Diabetic Supplies Update - Helpful Information for Providers

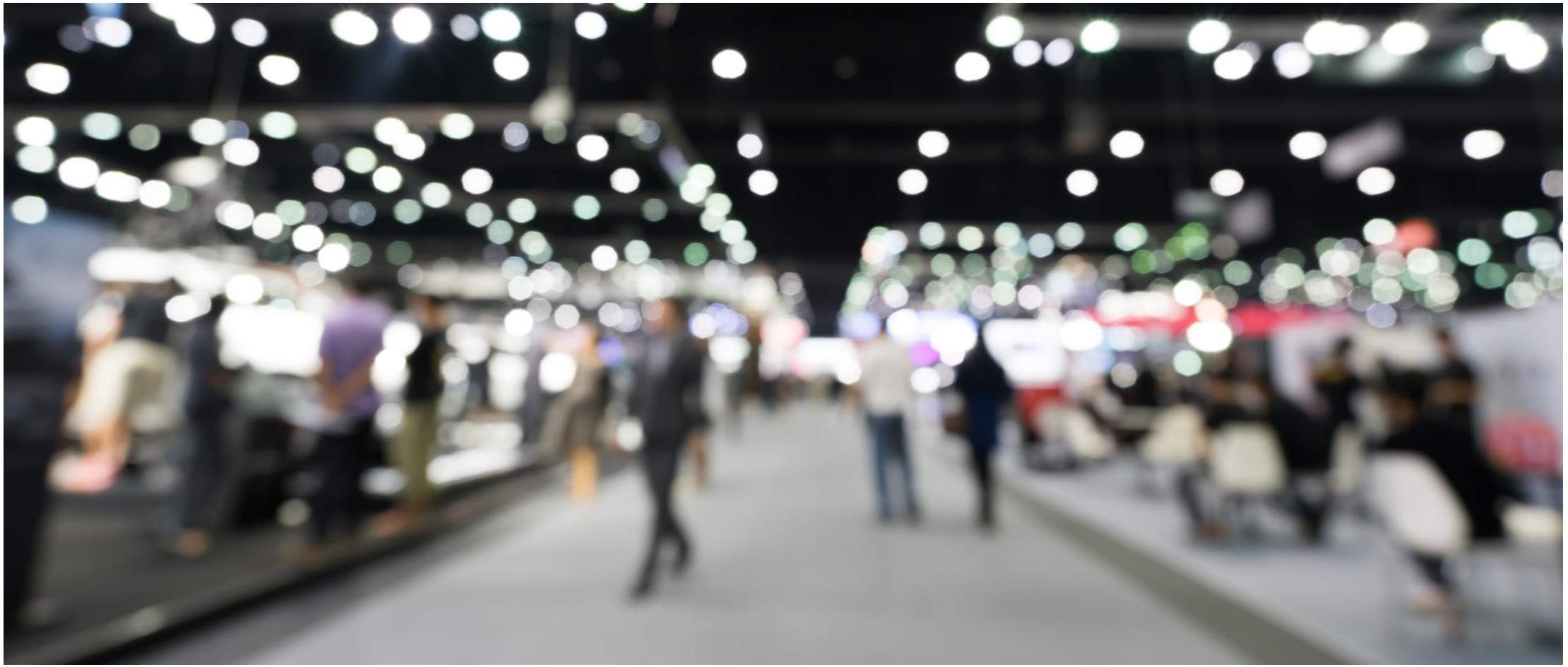
QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.

Any Questions?



Vendor Break



Poll Question

A request for an extension of benefits must be received within _____ calendar days of the date of the benefits-exhausted denial?

30 days	45 days	90 days	365 days

Poll Question

When searching claim status on the Arkansas Medicaid Healthcare portal, which panel do you open to see the denial reason of a claim?

Adjudication Errors Panel	Service Details Panel	Diagnosis Code Panel

Poll Question

Where do you find the Beneficiary Aid Category list?

Section II of the Arkansas Medicaid Provider Manual	Section III of the Arkansas Medicaid Provider Manual	Section I of the Arkansas Medicaid Provider Manual

Poll Question

What would you expect to find on a Procedure Code Table?

Procedure Codes	Age Restrictions	Diagnosis Groups	Prior Authorizations

All of the above

Poll Question

How many digits are in a Medicaid Provider ID?

Ten	Nine	Thirteen

Poll Question

What section of the Arkansas Medicaid Provider Manual is specific to your provider type?		
Section II of the Arkansas Medicaid Provider Manual	Section III of the Arkansas Medicaid Provider	Section IV of the Arkansas Medicaid Provider Manual

Poll Question

What is the color of the MMIS Outreach Team banner on their map?

Blue	Orange

Poll Question

What is Not a covered service under the Preventative Screening/Essential Health Benefits?		
Lipid	Mammogram	Mole Removal

Poll Question

Arkansas Medicaid established a maximum benefit limit of $_____ per SFY for diagnostic laboratory services and radiology.

1000	500	250

Poll Question

How often can you perform an EPSDT (Wellness) Screening on children 3 years through 20 years?

Every 365 Days	Once per birth year	Anytime you want

Eligibility Verification 101 — Deep Dive

Agenda

- Eligibility Verification — Deep Dive
- Training Tools to Determine Eligibility
- Evaluations
- Questions

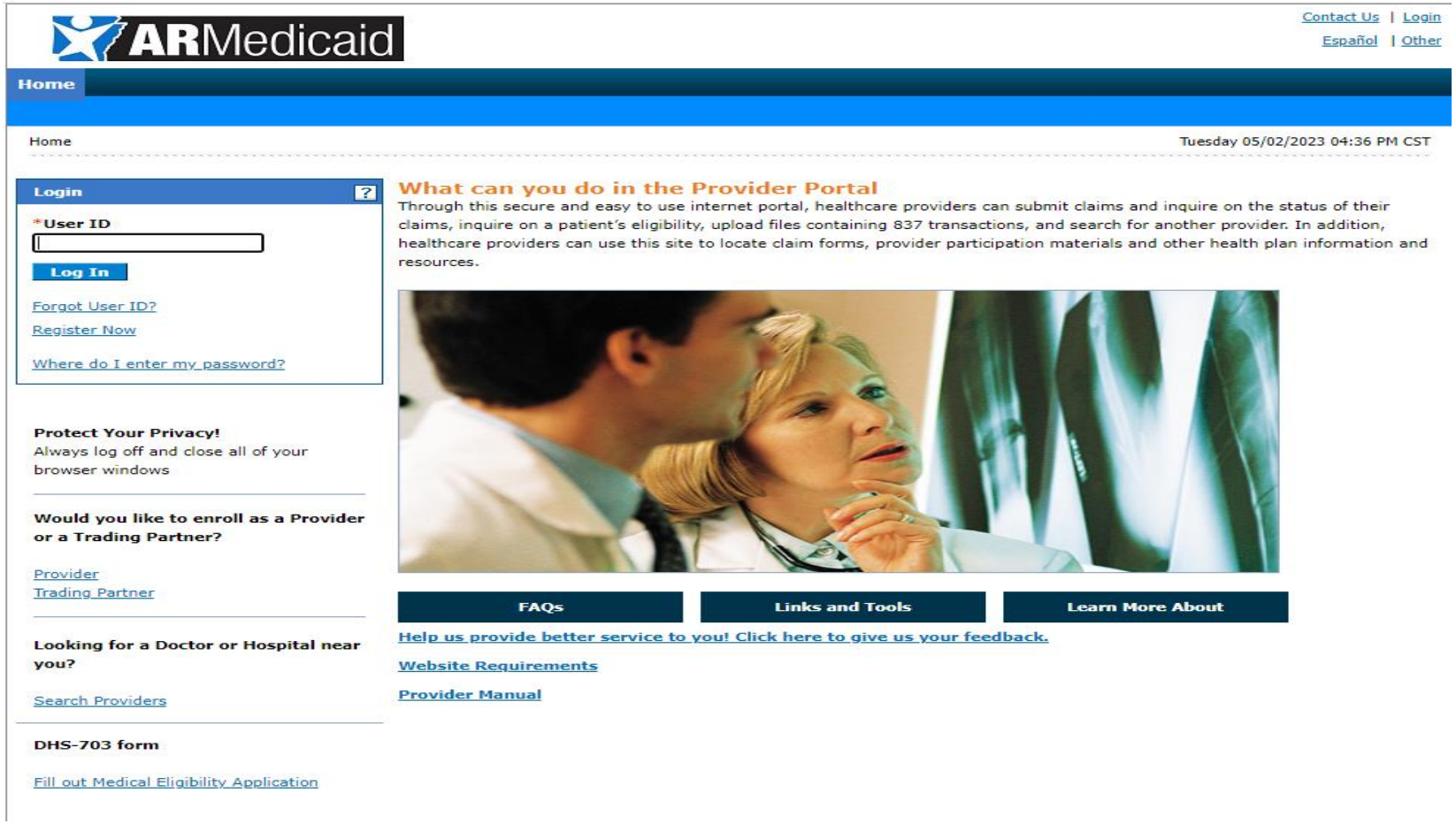
Beneficiary Aid Category List

Some categories provide a full range of benefits while others may offer limited benefits or may require cost sharing by a beneficiary. The following codes describe each level of coverage.

FR	full range
LB	limited benefits
AC	additional cost sharing
MNLB	medically needy limited benefits
QHP/IABP/MF	Qualified Health Plan/awaiting QHP assignment/medically frail

Category	Category Name	Description	Code
01	ARKIDS B	CHIP Separate Child Health Program	LB, AC
06	ARHOME	New Adult Expansion Group	QHP, AC IABP, AC MF, FR
10	WD	Workers with Disabilities	FR, AC
11	Assisted Individual - Aged	Assisted Living Facility- Individual is >= 65 years old	FR
11	ARChoices - Aged	ARChoices waiver -Individual is >= 65 years old	FR
13	SSI Aged Individual	SSI Medicaid	FR
14	SSI Aged Spouse	SSI Medicaid	FR
15	PACE	Program of All-Inclusive Care for the Elderly (PACE)	FR
16	AA-EC Aged Individual	Medically Needy, Exceptional Category-Individual is >= 65 years old	MNLB
17	AA-SD – Aged	Medically Needy Spend Down- Individual is >= 65 years old	MNLB
18 QMB	AA Aged Individual	Qualified Medicare Beneficiary (QMB)-Individual is >= 65 years old	LB
19	ARSeniors	ARSeniors	FR
20	PCR	Parent Caretaker Relative	FR
25	TM	Transitional Medicaid	FR, AC
26	AFDC Medically Needy-EC	AFDC Medically Needy Exceptional Category	MNLB
27	AFDC Medically Needy-SD	AFDC Medically Needy Spend Down	MNLB
31	Pickle	Disregard COLA Increase	FR
33	SSI Blind Individual	SSI Medicaid	FR
34	SSI Blind Spouse	SSI Medicaid	FR

Verifying Eligibility | Healthcare Provider Portal



Tips for Healthcare Portal

At least 5MB of upload and download speed

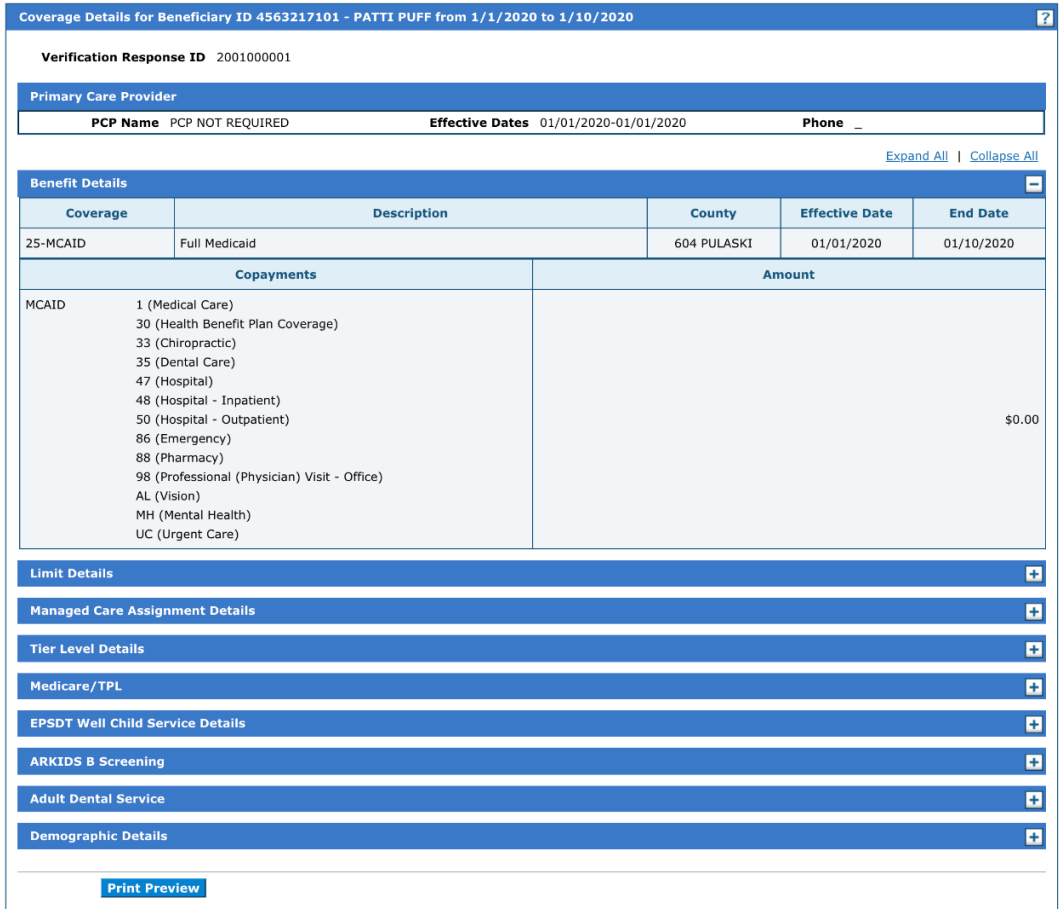
All users have their own username and password

Make sure staff that are no longer employed are changed to inactive on your profile

Verify eligibility the day you provide service

New Enhancement- claim attachments

Importance of Verifying Eligibility



Coverage Details for Beneficiary ID 4563217101 - PATTI PUFF from 1/1/2020 to 1/10/2020

Verification Response ID 2001000001

Primary Care Provider

PCP Name	Effective Dates	Phone
PCP NOT REQUIRED	01/01/2020-01/01/2020	_

Expand All | Collapse All

Benefit Details

Coverage	Description	County	Effective Date	End Date
25-MCAID	Full Medicaid	604 PULASKI	01/01/2020	01/10/2020

Copayments		Amount
MCAID	1 (Medical Care) 30 (Health Benefit Plan Coverage) 33 (Chiropractic) 35 (Dental Care) 47 (Hospital) 48 (Hospital - Inpatient) 50 (Hospital - Outpatient) 86 (Emergency) 88 (Pharmacy) 98 (Professional (Physician) Visit - Office) AL (Vision) MH (Mental Health) UC (Urgent Care)	$0.00

Limit Details

Managed Care Assignment Details

Tier Level Details

Medicare/TPL

EPSDT Well Child Service Details

ARKIDS B Screening

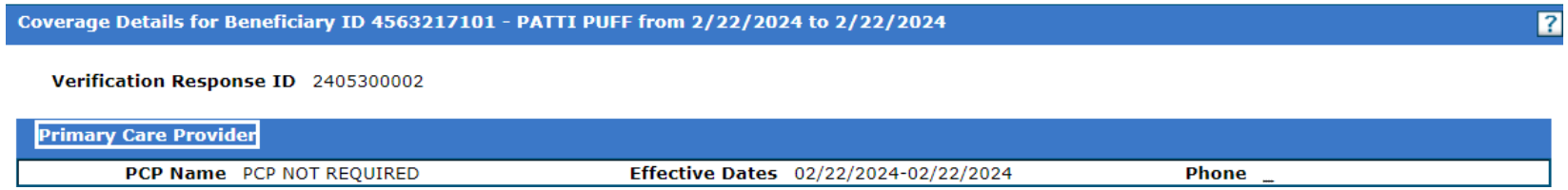
Adult Dental Service

Demographic Details

Print Preview

Primary Care Provider

- Displays if the Medicaid client has a Primary Care Physician, Effective Dates and PCP Phone number.
- If the client has a PCP and a referral is required for your procedure code/services, please make sure that you have a referral form from the PCP listed on the eligibility verification.
- Enter the PCP Provider ID on the claim.
- Referral can be in paper form or verbal.
- If a verbal referral is given, ensure that you get: Name of the person that you spoke with who gave you the referral. ***Documentation is key!***
- PCP referrals expire on the date specified by the PCP, upon receipt of the number of services specified by the PCP, or in six months, whichever occurs first.



Benefit Details

- This panel will display what coverage the client has (please refer to the Aid Category List) to determine if the client has:
  - **FR** — full range
  - **LB** — limited benefits
  - **AC** — additional cost sharing
  - **MN** — medically needy limited benefits
  - **QHP** — Qualified Health Plan/awaiting assignment
- Refer to Section 124.000 for full detail of each category.

Benefit Details

Coverage	Description	County	Effective Date	End Date
40-MLTD	Long Term Care Disabled	604 PULASKI	02/22/2024	02/22/2024

Copayments		Amount	Elig Effective Date	Elig End Date
40-MLTD	1 (Medical Care) 30 (Health Benefit Plan Coverage) 33 (Chiropractic) 35 (Dental Care) 47 (Hospital) 48 (Hospital - Inpatient) 50 (Hospital - Outpatient) 86 (Emergency) 88 (Pharmacy) 98 (Professional (Physician) Visit - Office) AL (Vision) AM (Vision Frames) MH (Mental Health) UC (Urgent Care)	$0.00	02/22/2024	02/22/2024

Limit Details

- Displays the number of benefits that are left at the time you verify eligibility.
- Fiscal Year is July 1st – June 30th
- $500 Lab
- $500 Xray
- 12 Outpatient Visits
- 16 Office Visits — this is not limited to just Office visits, it includes…….

- Benefits start over July 1st each year!

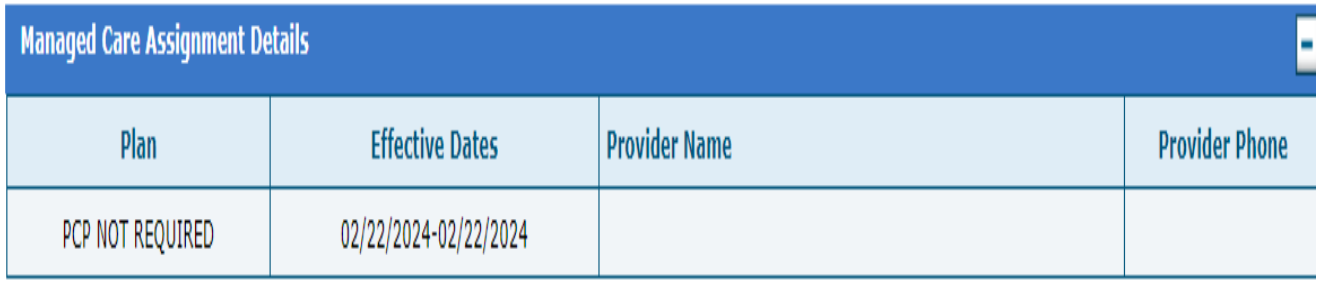
Limit Details

The Dollar Limits and Service Limits may not reflect recent claims. The remaining service limit balance is contingent upon verifying that the benefit plan allows for the usage of any remaining balances.

Dollar Limit	Limit	Remaining	Effective Date	End Date	Last Service
5106 LAB SERVICES LIMITED TO $500 PER SFY	$500.00	$500.00	07/01/2023	02/22/2024	N/A
5107 RADIOLOGY/OTHER SERVICES LIMITED TO $500 PER	$500.00	$500.00	07/01/2023	02/22/2024	N/A
6312 ADULT DENTAL SERVICES LIMITED TO $500 PER SFY	$500.00	$500.00	07/01/2023	02/22/2024	N/A
Service Limit	**Limit**	**Remaining**	**Effective Date**	**End Date**	**Last Service**
5124 LIMIT 12 PROFESSIONAL OUTPATIENT HOSPITAL VIS	12	12	07/01/2023	02/22/2024	N/A
AM - FRAMES	1.00	1.00	02/23/2023	02/22/2024	N/A
AO - LENSES	2.00	2.00	02/23/2023	02/22/2024	N/A
6120 PERSONAL CARE SRVC-LIMIT 256 UNTS/CAL MNTH	256.00	256.00	02/01/2024	02/22/2024	N/A
6231 EYE EXAM LIMITED TO ONE PER 12 MONTHS	1.00	1.00	02/23/2023	02/22/2024	N/A
6232 EYEGLASS REPAIR LIMITED TO ONCE PER 12 MO	1	1	02/23/2023	02/22/2024	N/A
6313 ORTHODONTIC LIMITED TO 1 PER LIFETIME	1.0	1.0	07/15/1963	02/22/2024	N/A
6610 MAXIMUM OF 12 CHIROPRACTIC VISITS PER SFY	12.00	12.00	07/01/2023	02/22/2024	N/A
6732 MAX OF TWO CONSULTATIONS PER STATE FISCAL YEA	2.00	2.00	07/01/2023	02/22/2024	N/A
6890 16 PROVIDER VISITS PER SFY	16.00	16.00	07/01/2023	02/22/2024	N/A

Managed Care Assignment Details

- Displays the Manage Care Provider for the Medicaid Client
- This can include:
  - Non-Emergency Transportation
  - Dental Managed Care — Delta Dental Smiles and MCNA
  - PASSE Providers — AR Total Care, CareSource, Empower, Summit
  - Primary Care Physician
  - AR Home — Qualified Health Plan (QHP) such as Ambetter, Blue Cross Blue Shield, Qualchoice, etc.


Managed Care Assignment Details

Plan	Effective Dates	Provider Name	Provider Phone
PCP NOT REQUIRED	02/22/2024-02/22/2024		

Tier Level Details

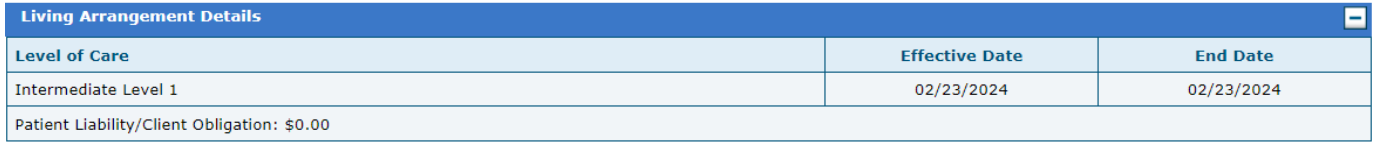
- Displays assessment information to providers for members enrolled in the following categories:
  - Division of Aging and Adult Service (DAAS)
  - Provider Led Arkansas Shared Savings Entity (PASSE)
  - Division of Behavioral Health Services (DBHS)
- This will assist providers to give all information so that if an independent assessment is expiring that they have a mechanism to check this information.

Tier Level Details

Division	Tier Level	Assessment Date	Assessment End Date
DAAS	2	10/30/2023	12/31/2299
DAAS	1	12/02/2022	12/31/2299

Living Arrangement

- Displays the Living Arrangements and Level of Care for Medicaid clients in the following categories:
  - Hospice
  - Nursing Home
  - Patient Liability



Living Arrangement Details

Level of Care	Effective Date	End Date
Intermediate Level 1	02/23/2024	02/23/2024
Patient Liability/Client Obligation: $0.00		

Medicare/TPL

- **Medicare** — displays if a Medicaid client has Medicare Part A, Part B, Medicare A Buy-In or Medicare B Buy-In.
- **TPL** — displays if a Medicaid client has Third Party Liability (Other Insurance).

Medicare/TPL

Carrier	Effective Date	End Date
Medicare A	N/A	N/A
Medicare B	N/A	N/A
Med A/Buyin	N/A	N/A
Med B/Buyin	N/A	N/A

EPSDT Well Child Services Details

- Displays the Last and the Next Exam for **Medical, Dental, Vision,** and **Hearing** screening date for a Medicaid client.

EPSDT Well Child Service Details

Service	Last Exam	Next Exam
EPSDT Medical Screening	N/A	N/A
EPSDT Dental Screening	N/A	N/A
EPSDT Vision Screening	N/A	N/A
EPSDT Hearing Screening	N/A	N/A

ARKids B Screening

- Displays the Last and the Next Exam for **Medical, Dental, Vision,** and **Hearing** screening date.

ARKIDS B Screening		
Service	**Last Exam**	**Next Exam**
ARKIDS B Medical Screening	N/A	N/A
ARKIDS B Dental Screening	N/A	N/A
ARKIDS B Vision Screening	N/A	N/A
ARKIDS B Hearing Screening	N/A	N/A

Adult Dental Service

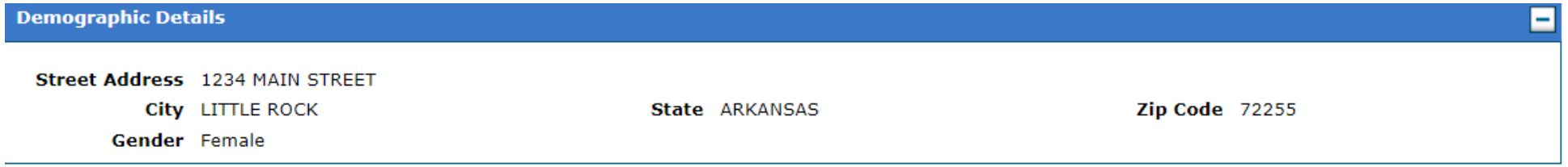
- Displays the Last Date of Service for a Medicaid client's dental services.

Adult Dental Service

Service	Last Date of Service
Panoramic/Full mouth X-ray - D0330	N/A
Panoramic/Full mouth X-ray - D0210	N/A
Bite Wings - D0272	N/A
Prophylaxis/Fluoride - D1110	N/A
Prophylaxis/Fluoride - D1120	N/A
Prophylaxis/Fluoride - D1206	N/A
Prophylaxis/Fluoride - D1208	N/A
Limited ER/Oral Evaluation/Problem Focused - D0140	N/A
Intraoral Periapical First Radiographic Imagine - D0220	N/A
Intraoral Periapical Each Additional Radiographic Imagine - D0230	N/A
Intraoral-Occlusal Radiographic Imagine - D0240	N/A
Extraoral First Radiographic Imagine - D0250	N/A
Sealant - D1351 Tooth 1	N/A
Sealant - D1351 Tooth 2	N/A
Sealant - D1351 Tooth 3	N/A
Sealant - D1351 Tooth 14	N/A
Sealant - D1351 Tooth 15	N/A
Sealant - D1351 Tooth 18	N/A
Sealant - D1351 Tooth 19	N/A
Sealant - D1351 Tooth 30	N/A
Sealant - D1351 Tooth 31	N/A

Demographic Details

- Displays the Medicaid client's Street Address, City, State, Zip Code, and Gender according to the Medicaid system.



Other Insurance Detail Information

- Displays the Other Insurance Detail Information that we have on file. If this is incorrect, you have the option to Add New Other Insurance when you file the claim.
- You can also contact the Third-Party Liability Unit at the State to update TPL information.

(501) 537-1070

(501) 682-1644

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

Eligibility Verification Tips

Verify Eligibility the ***day*** you provide services

Refer to the Aid Category List

Make sure you have a referral for services that require a PCP referral

Pay close attention to Limit Details to ensure that have available benefits/visits.

Tools to Determine Eligibility

Beneficiary Aid Category List ***AND*** Section 1 (124.000) of your Provider Manual View or print the Client Aid Category list

Eligibility verification job aid — Eligibility Verification

Eligibility Verification Video — Eligibility Verification Video

Medicaid Tools and Resources

DHS/DMS website: Helpful Information for Providers

- Provider manuals
- Procedure code tables
- Fee schedule
- Frequently asked questions (FAQs)
- Vendor specifications
- Job aids
- Quick Track Training videos and guides
- MyARMedicaid Application

Download the MyARMedicaid App

BENEFITS

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

HOW TO SIGN UP

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

Download on the App Store | GET IT ON Google Play

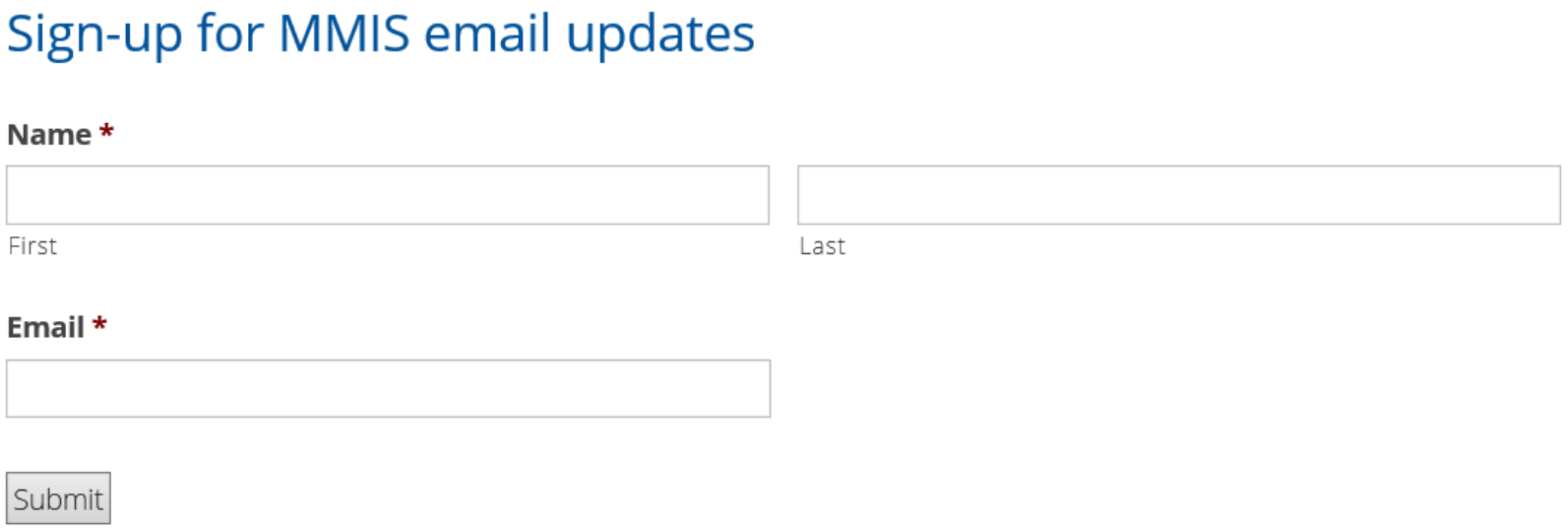
- **Through the web**
  - Go to the MyARMedicaid website at https://mdp.mmis.arkansas.gov/.
  - Create an account and log in to see the benefits.

Donaghey Plaza, P.O. Box 1437, Little Rock, AR 72203 501.682.1001 HUMANSERVICES.ARKANSAS.GOV

Medicaid Contacts

- Division of Medical Services (DMS)
  https://humanservices.arkansas.gov/offices
- County offices (DCO)
  https://humanservices.arkansas.gov/find-a-county-office/
- AFMC
  afmc.org
  - MMIS outreach specialists — 501-906-7566, afmc.org/mmis
  - ConnectCare — 1-800-275-1131, seeyourdoc.org
  - Provider relations outreach specialists— afmc.org/providerrelations
  - AFMC Clinical Services — 479-649-8501, clinicalservices@afmc.org
- Accentra (formerly Kepro) — Prior authorization and extension of benefits
  - Website: AR.EQHS.com
    AR.PR@KEPRO.COM or 1-888-660-3831
- Office of Medicaid Inspector General (OMIG) — 1-855-527-6644
- Magellan Medicaid Administration pharmacy help desk — 1-800-424-7895, Option 2 for prescribers
- Gainwell Technologies — 1-800-457-4454
- PASSE — DHS PASSE provider call center — 1-888-889-6451
- MCNA Dental — 1-800-494-MCNA
- Delta Dental Smiles Customer Service — 1-866-864-2499

E-Blast Sign-Up Link



[AFMC MMIS E-Blast Sign-Up Link]

QR Code to Access Training Resources

Use your IOS, Android or any device to access all our MMIS Tools and Resources for your convenience.

Evaluations

Your feedback is important to us!

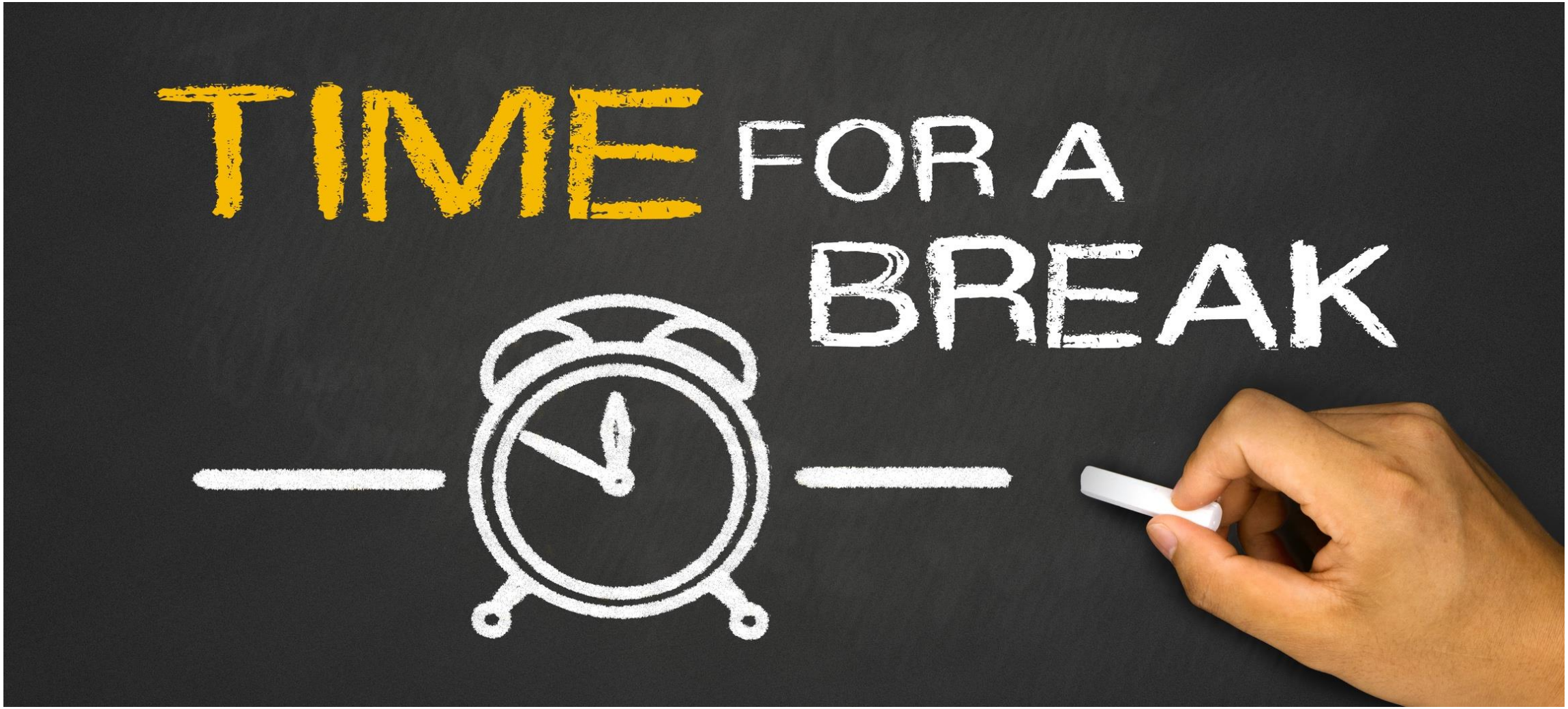
A conference evaluation will be emailed to you. Please take time to complete it.

Upon completion of the evaluation, a printable attendance certificate will be available for you.

Thank you for attending today!


Q&A

Afternoon Session
1:00 – 3:30 p.m.
Please be sure to come back!


TIME FOR A
BREAK