

AFMC Provider Relations

Carla Hestir, AFMC, Team Lead, Outreach Specialist

Shawna Branscum, AFMC, Outreach Specialist

EPSDT

Early And Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT screens include the following components:

- Health and Developmental History
- Unclothed Physical Examination
- Developmental Assessment
- Visual Evaluation
- Hearing Evaluation
- Oral Assessment (Dental Screening)
- Laboratory Procedures (Lead Toxicity Screening)
- Nutritional Assessment
- Health Education

Refer to EPSDT manual sections 215.200-219.00 and ARKids B manual sections 222.700-222.850 for detailed policy guidance of each EPSDT component.

EPSDT and Wellness Exams Periodicity Schedule

- From birth to 15 months of age, beneficiaries may receive seven (7) periodic screens in addition to the newborn screen performed in the hospital.
- Beneficiaries age 15 months to 24 months of age may receive two (2) periodic screens.
- Beneficiaries age 24 months to 30 months may receive one (1) periodic screen, and beneficiaries 30 months to 3 years old may receive one (1) periodic screen.
- When a beneficiary has turned 3 years old, they may receive one exam beginning at age 3 any time after the beneficiary has their birthday in that year. There no longer needs to be 365 + 1 days between EPSDT/Wellness exams. The EPSDT and ARKids B manuals have been updated to reflect this policy change.
- When a beneficiary ages out of ARKids A and ARKids B at age 19, if they apply and qualify for continued Medicaid coverage and are placed in a benefit aid category which offers all Medicaid benefits, they can receive an EPSDT screen at age 19 and 20.
- EPSDT services are federally mandated services which state Medicaid plans cover for those who qualify, through age 20.

Procedure Code 96110

- Billable developmental screens started January 1, 2024
 - Rate - \$8.80 per screen
- Procedure code table definition – Children’s Core Developmental Screen w/Score
- The developmental screen instrument used must be a validated tool recommended by the American Academy of Pediatrics. A list of validated screening tools can be found in the Screening Tool Finder in the American Academy of Pediatrics “Screening Technical Assistance and Resource (STAR) Center at this link: <https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/>
- PCPs will be allowed to bill procedure code 96110 as follows:
 - One (1) unit before twelve (12) months of age;
 - Two (2) units (but no more than one per year) between the ages of thirteen (13) to forty-eight (48) months; and
 - Starting April 1, 2024, one (1) unit between the ages of forty-eight (48) to sixty (60) months.

Early Intervention Day Treatment (EIDT) Referral Process Changes

Early Intervention Day Treatment (EIDT) Screening

A developmental screening must be performed prior to signing a DHS-642 ER referring a beneficiary for their initial evaluations to determine eligibility for early intervention day treatment (EIDT) services.

- A. A developmental screening **is only required prior to initially referring** a beneficiary for EIDT services. A developmental screening is not required to be performed on a beneficiary already receiving EIDT services.
- B. The developmental screening must have been administered within the twelve (12) months immediately preceding the date of the DHS-642 ER.
- C. The developmental screen instrument used must be a validated tool recommended by the American Academy of Pediatrics.

Child Health Services/EPSTD manual section 215.295

Process Changes – EIDT Services for Children

- As of April 1, 2024, the child's **Primary Care Provider (PCP)** will administer and analyze the required developmental screen for initial EIDT eligibility determination purposes, rather than an outside vendor.
- A list of validated screening tools can be found in the Screening Tool Finder in the American Academy of Pediatrics "Screening Technical Assistance and Resource (STAR) Center at this link: <https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/>
- **Please note: A PCP administered developmental screen is not a prerequisite to demonstrate continued eligibility for children already receiving EIDT services. It is only required when determining a child's initial eligibility for EIDT services.**

Single Entity Update

CMS Directive

- Single Entity Providers
 - Transitioned 11/1/2023
 - 20 UAMS/AHEC facilities
 - 192 FQHC facilities
- School-Based Mental Health Providers
 - Transitioned 4/1/2024
 - 21 SBMH facilities

School-Based Mental Health

- Providers who can bill as a school based mental health provider:
 - Independently Licensed Provider (ILP)
 - Hired by the school - Performing provider type 19; POS 03: Bill to 91
 - Non-independently Licensed Provider
 - Hired by school with supervision. Documentation should support supervision.
Performing provider type 95; POS 03; Bill to 91

- This change was effective April 1, 2024.

FQHC Updates

- Billing Codes:
 - T1015 U5 - first medical encounter
 - Scope includes behavioral health services
 - Bill with physician, DO or APN as rendering (MD, DO or APN)
 - T1015 U5 UA - second encounter
 - Bill with physician, DO or APN as rendering (MD, DO or APN)
 - T1015 U5 UB – counseling services only encounter
 - Bill with behavioral health provider as rendering

- **Claims prior to 4/3/24 should be billed with the FQHC as the rendering provider.**
- **The rules to require an individual provider on claims was implemented on 4/3/24.**
- **Any FQHC mental health claims billed as FQHC (49) as the rendering after 4/2/24 will deny.**

Behavioral Health Integration

Behavioral Health Counseling Services

■ Counseling Services


- The counseling procedures covered under the Physician Program are allowed as a covered service when provided by the physician or when provided by a qualified practitioner who by State licensure is authorized to provide them. Only one (1) counseling visit per day is allowed in the physician's office, the outpatient hospital, or nursing home. Place of Service Code 22 Outpatient Hospital, 11 Doctor's Office and 12 Patient's Home.

■ Behavioral Health Screen

- A physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization.

[Physician manual section 205.100, 292.740, 292.741](#)

Behavioral Health Outpatient Counseling

 Outpatient Counseling no longer requires a PCP referral

172.100 Services not Requiring a PCP Referral 2-1-24

M. Mental health services, as follows:

1. Psychiatry for services provided by a psychiatrist enrolled in Arkansas Medicaid and practicing as an individual practitioner
2. Medication Assisted Treatment for Opioid Use Disorder
3. Rehabilitative Services for Youth and Children (RSYC) Program
4. **Outpatient counseling services**

Caregiver Depression Screening

292.741

Behavioral Health Screen

1-1-23

A physician, physician's assistant, or advanced nurse practitioner may administer a brief standardized emotional/behavioral assessment screening to a client along with an office visit. The allowable screening is up to two (2) units per visit and is allowable up to four (4) times per state fiscal year without prior authorization. An extension of benefits may be requested if additional screening is medically necessary. If a client is under the age of eighteen (18), and the parent/legal guardian appears depressed, he or she can be screened as well, and the screening 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.

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

Independent Assessment

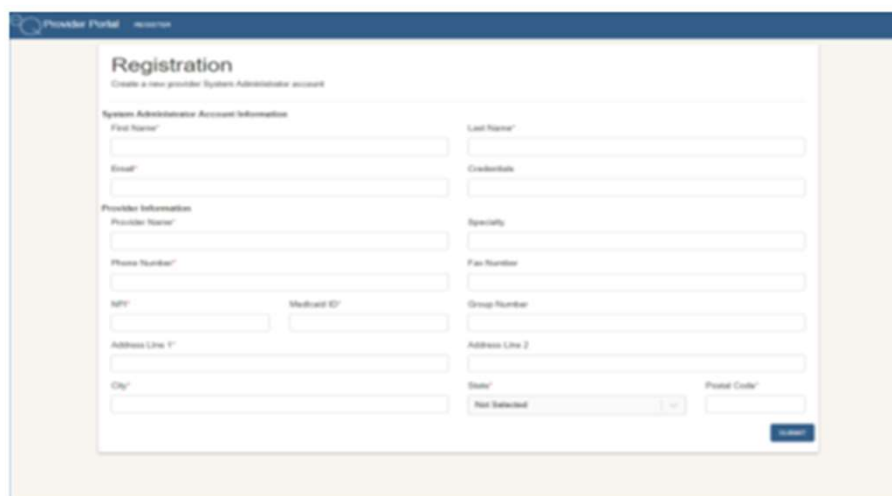
Referral Process

Independent Assessment – Who Needs a Referral?

- Behavioral Health (BH) Independent Assessment (IA) referrals for consideration of placement in a Tier 2 or Tier 3 PASSE are needed for:
 - Any youth who is receiving outpatient counseling services for a mental health or substance use disorder and **is not responding to treatment**.
 - Any youth identified as in need of home and community based or residential services to treat a mental health or substance use disorder.
 - Since a screening tool does not diagnose a mental health disorder, an IA referral should not be submitted based solely on a screening tool. If the PCP office does not provide counseling services, families can be referred to the Mental Health & Addiction Support Line (844-763-0198) for a list of mental health providers.

Submit an Independent Assessment Referral

- Online Provider Portal Registration is Available - <https://ar.eqhs.com>
- Check your email for a confirmation email and follow the instructions to activate your new Provider Portal account.



The screenshot shows a web form titled "Registration" with the subtitle "Create a new provider System Administrator account". The form is divided into two main sections: "System Administrator Account Information" and "Provider Information".


System Administrator Account Information:

- First Name*
- Last Name*
- Email*
- Username*

Provider Information:

- Provider Name*
- Specialty*
- Phone Number*
- Fax Number*
- NPI*
- Medical ID*
- Group Number*
- Address Line 1*
- Address Line 2*
- City*
- State* (dropdown menu)
- Postal Code*

A "Submit" button is located at the bottom right of the form.



The screenshot shows an email confirmation message. It is titled "Registration" with the subtitle "Create a new provider System Administrator account".

Please check your Email Inbox. An email with an embedded link has been sent to ar@eqhs.org. To confirm your newly registered account please follow the directions in this email.

MISC

Vaccine Counseling for EPSDT Members

- Arkansas Department of Human Services added coverage for procedure codes G0312 EP and G0315 EP effective 4/1/2024. This will align with CMS guidance to cover stand-alone vaccination counseling in the EPSDT Program.
- A total of four (4) Vaccine Counseling sessions (G0312 EP or G0315 EP) may be billed per State Fiscal Year (SFY). An extension of benefits (under Process Type 126 – Professional Services) can be obtained through the Provider Portal and will be reviewed by Arkansas Foundation for Medical Care (AFMC).
- The following procedure codes are effective 4/1/2024 under the Medical Services (MEDSV) and Nurse Practitioner (NURSP) Contracts:

Proc Code	Description	Mod	Provider Contract	Age Limits
G0312	IMMUNIZE COUNS < 21YR 5-15 M	EP	MEDSV & NURSP	0-20 yrs.
G0315	COUNSEL IMMUNE < 21YR 5-15 M	EP	MEDSV & NURSP	0-20 yrs.

Review the official notice - <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/official-notices/>

Long-Acting Reversible Contraceptive (LARC) Covered During Inpatient Stay

General Information

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

Billing Guidelines

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

Review the official notice - <https://humanservices.arkansas.gov/divisions-shared-services/medical-services/official-notices/>

Pregnant Women Medicaid Coverage

TO: Health Care Providers – All Providers
DATE: December 29, 2022
SUBJECT: Limited Women Program Ending 12/31/2022

I. General Information

Arkansas Department of Human Services has expanded coverage for pregnant woman. With this expansion, the Limited benefit Pregnant Woman (LPW) program will be ending 12/31/2022. Effective January 1, 2023, clients who were receiving LPW services, will now be receiving full Pregnant Women Medicaid Benefits.

The applicable Provider Manuals (Hospital, Nurse Practitioner, Certified Nurse Midwife, Physicians, and ARKids First-B) and Medical Services Policy Manual (sections E and F) will be updated to reflect these changes on January 1, 2023.

61	Unborn	Pregnant Women - Unborn Child (No family planning benefits allowed)	LB
65	Pregnant Women – Full	Pregnant Women – Full	FR
66	Pregnant Women Medically Needy - EC	AFDC Pregnant Women Medically Needy	MNLB
67	Pregnant Women Medically Needy - SD	AFDC Pregnant Women Medically Needy Spend Down	MNLB

Physician Assistants Enrollment Changes

- Enrollment status update
 - Current - Provider type 95, specialty NT
 - New - Provider type 12, Specialty NV
- Action required
 - Before July 1, 2024
- Change in enrollment status
 - Allow Physician Assistants to bill, refer, and order
- ***Provider type 95, specialty NT will be deactivated 7/1/2024***

Important Information

1. **Effective Date:** Starting **April 1, 2024**, Physician Assistants (PAs) will be able to submit applications under the new **Provider Type 12 Specialty NV**.
2. **Billing Transition Period:** Until **July 1, 2024**, PAs should continue to bill using the current **PT 95 NV** for services provided. During this transition period, it's essential to follow the existing billing procedures.
3. **Mandatory PT 12 After July 1, 2024:** After **July 1, 2024**, all PAs must have an active **PT 12** for claims submissions. Please ensure that you apply for PT 12 promptly to avoid any disruptions in claims processing.
4. **Application Submission Options:** You can submit your PT 12 OR PT 95 application through the **AR Medicaid enrollment portal**.
5. **Deactivation of PT 95 Numbers:** All active **PT 95 specialty NV numbers** will be **deactivated** on **July 1, 2024**. To continue providing services, make sure you have an active PT 12 Specialty NV Medicaid ID.

Important Information Cont.

6. **Revalidation Every 5 Years:** The conversion from PT 95 to PT 12 requires providers to revalidate their status every 5 years. This ensures compliance and maintains accurate records.
7. **Direct Billing Capability:** PT 12 allows for certain billings to be submitted directly or as a rendering provider.
8. **Start Your Application Electronically:** Use this link to begin your application electronically. Completing your submission through the portal makes it easy for you to have online access to your application status and helps collect all necessary information for efficient processing.

[Enrollment Application](#)

Initiate a New Enrollment application.

[Resume Enrollment](#)

Resume an existing application that you previously started or respond to an RTP. “Return To Provider”

[Enrollment Status](#)

Check the current status of an enrollment application.

Resources

AFMC Provider Relations

AFMC Provider Relations Website

■ www.afmc.org/providerrelations – Policy and Education

- AR Physician Medicaid Updates
- Provider Communication E-Blasts
 - Current and Archived
- Provider Relations Webinars
 - Current and Archived
 - ARHome
 - PCMH
 - Primary Care Providers/Specialists
 - MAT



Provider Relations Outreach Specialists Information Sheet

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

AFMC OUTREACH SPECIALISTS

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

Manager, Outreach Services

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

Supervisor, Provider Relations

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

Outreach Specialists

 Emily Alexander 501-804-0184
ealexander@afmc.org

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

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

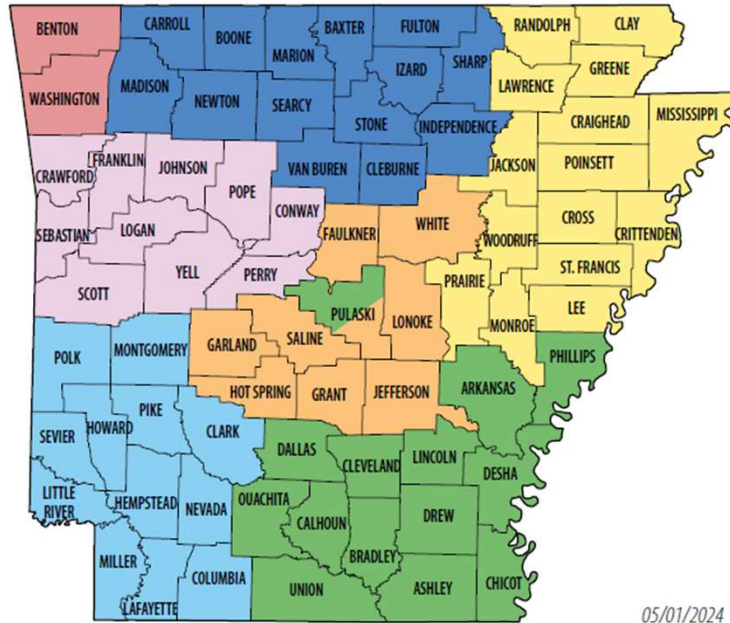
 Jackie Clarkson 501-553-7665
jclarkson@afmc.org

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

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

Supervisor, Outreach Logistics

Tonya Long 501-212-8686
tlong@afmc.org



05/01/2024

GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

Gainwell Provider Assistance Center

In-state toll free 800-457-4454
Local & out-of-state 501-376-2211
Gainwell Provider Services Manager
Tyler Brickley 501-590-6325

Gainwell Technologies Services

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES



CONNECTCARE - BENEFICIARY SERVICES

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

• Toll free 800-275-1131

MEDICAID FRAUD CONTROL UNIT (PROVIDERS)

• Central Arkansas 501-682-8349

VOICE RESPONSE SYSTEM - PCP ASSIGNMENT

• Toll free 800-805-1512

PCMH QUESTIONS PCMH@afmc.org

MAGELLAN MEDICAID ADMINISTRATION

• Pharmacy Help Desk.. 800-424-7895

THIRD PARTY LIABILITY

• Local 501-537-1070
• Fax 501-682-1644

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

Questions?