SECTION II - ARKANSAS COVID RESPONSE

CONTENTS

200.000 OVERVIEW

201.000 Authority

The following rules are duly adopted and promulgated by the Arkansas Department of Human Services (DHS) under the authority of Arkansas Code Annotated §§ §§ 20-10-203, 20-10-701, 20-38-103, 20-38-112, 20-48-103, 20-76-201, 20-76-401, 20-77-107, 20-80-306 to -311, 25-10-126, and 25-10-129.

202.000 Purpose

In response to the COVID 19 pandemic, DHS identified programs and services that required additional flexibility or changes to adapt to ensuring the health and safety of our clients. This manual details them so that DHS may render uninterrupted assistance and services to our clients.

203.000 Appeals

Appeal requests for the Covid response policies must adhere to the policy set forth in the Medicaid Provider Manual Section 160.000 Administrative Reconsideration and Appeals which can be accessed at **https://medicaid.mmis.arkansas.gov/Provider/Docs/all.aspx.**

203.000 Severability

Each section of this manual is severable from all others. If any section of this manual is held to be invalid, illegal, or unenforceable, such determination shall not affect the validity of other sections in this manual and all such other sections shall remain in full force and effect. In such an event, all other sections shall be construed and enforced as if this section had not been included therein.

210.000 AGING AND ADULT

211.000 Extension of Person-Centered Service Plans -- ARChoices, Living Choices and PACE

The Person-Centered Service Plan (PCSP) serves to document the level of service need and is the official plan of care for those beneficiaries who have been found medically eligible for services.

Agency nurses should be able to extend PCSPs and authorizations based on review of current medical/functional needs. DAABHS nurses will complete an evaluation of the beneficiary's current needs and will extend the dates for qualifying beneficiaries, ensuring continued eligibility for services. PCSPs are living documents and are to be updated as goals and needs are met. During the extension period, the PCSP will continue to be updated to the level of current service needs based on continued phone contact with beneficiary.

The following rule provisions are suspended until December 31, 2021.

ARChoices:	212.312 which requires that a PCSP expiration date be 365 days from the date of the DHS RN's signature of the AAS-9503, the ARChoices PCSP.
Living Choices:	211.150 The Independent Assessment Contractor RN performs an assessment periodically (at least annually), and the Division of County Operations re-determines level of care annually. The results of the level of care determination and the re-evaluation are documented on form DHS-704. 212.200 Each Living Choices beneficiary will be evaluated at least annually by a DHS RN. The DHS RN evaluates the resident to determine whether a nursing home intermediate level of care is still appropriate and whether the plan of care should continue unchanged or be revised.
PACE:	212.200 involving involuntary dismissal of a Program of All-Inclusive Care for the Elderly (PACE) patient. 215.200 (B) and (C) require semi-annual and annual evaluations by providers.

These services will be available until December 31, 2021.

212.000 ARChoices, Living Choices and PACE Manual –Suspension of Timelines for Evaluation

Families First Corona Virus Response Act requires states to maintain an individual eligibility for amount, duration, and scope of benefits during the public health emergency ArChoices, Living Choices and PACE clients who do not receive an evaluation within 365 days of their existing eligibility date would be transitioned to traditional Medicaid or lose access to care under these programs.

This rule is suspended to allow members who do not receive a timely evaluation to remain eligible for ARChoices, Living Choices and PACE.

ARChoices	212.312 which requires functional eligibility be determined prior to the expiration of financial and functional eligibility
Living Choices	211.150 which requires that an evaluation is completed annually by DHS RN to help inform the determination of functional eligibility
PACE	212.200 which refers to involuntary dismissal of a PACE patient.

These services will be available until December 31, 2021.

213.000 Living Choices Assisted Living Facilities Reimbursement Rate

The rate reduction scheduled to occur January 1, 2021 will be suspended resulting in additional cost to the Medicaid program of $4.36 dollars per client day.

220.000 BEHAVIORAL HEALTH

221.000 Outpatient Behavioral Health Agencies Certified as Acute Crisis Units.

DMS is suspending the Acute Crisis Unit benefit limits of 96 hours per encounter, one encounter per month, and 6 encounters per state fiscal year. The rule to be suspended is in Section 253.003 of the Outpatient Behavioral Health Services Provider Manual.

The allowable code for this rule suspension:

- Acute Crisis Unit
- H0018 U4
- Benefit Limits 96 hours or less per encounter, 1 encounter per month, 6 encounters per SFY

These services will be available until December 31, 2021.

240.000 DEVELOPMENTAL DISABILITIES AND DELAYS

241.000 First Connections Developmental Therapy Telemedicine

During a public health emergency, the Office of Special Education Programs (OSEP) requires that eligible children with disabilities have continuity of Individual Family Service Plan (IFSP) services provided through alternative means such as teletherapy or other video conferencing. Currently, Medicaid's telehealth policies exclude Developmental Therapists from providing teletherapy services. First Connections needs a way to continue to provide developmental and consultative services to parents/guardians to support program-eligible children in developing and learning functional skills.

This method will be available until December 31, 2021.

- Modification to use teletherapy to provide developmental therapy/consultative services (DT) to parents/guardians of eligible children 0-3 with a current IFSP to help parents help their

child develop and learn as required by IDEA, Part C.

- DT is provided to parents/guardians of eligible children through accessible real-time technology which includes a video component with originating site requirements removed so that families can receive services from their home (maximum 60 minutes per week).

- DT through teletherapy must be billed to the First Connections grant. T1027 Developmental Therapy is prior authorized at $18.00 per unit and T1027 modifier UB Developmental Therapy Assistant is prior authorized at $15.00 per unit.

242.000 Adult Developmental Day Treatment and Early Intervention Day Treatment Nursing Services Outside Clinic

In response to the COVID-19 outbreak in Arkansas and consistent with CMS's coverage and payment for COVID-19, DMS/DDS is suspending the prohibition on use of nursing services to be provided outside of an Early Intervention Day Treatment (EIDT) Clinic and an Adult Development Day Treatment (ADDT) Clinic setting (49), limited to provider type 24 only for services provided to established patients during the COVID-19 outbreak and the declaration of public health emergency. This addendum expands allowable services to be done in a home setting (12) provided by licensed Registered Nurses and Licensed Practical Nurses.

This service will be available until December 31, 2021.

Nursing services are defined as the following, or similar, activities:

A. Assisting ventilator-dependent beneficiaries

B. Tracheostomy: suctioning and care

C. Feeding tube: feeding, care and maintenance

D. Catheterizations

E. Breathing treatments

F. Monitoring of vital statistics, including diabetes sugar checks, insulin, blood draws, and pulse ox

G. Administration of medication

Billing Information:

T1002 – Registered Nurse, services up to 15 minutes

T1003 – Licensed Practical Nurse, services up to 15 minutes

243.000 Prescription and Evaluation Extensions

In response to the COVID-19 outbreak, DMS/DDS will allow extensions on re-evaluations and treatment prescriptions for ADDT, EIDT, ABA, OT, PT, Speech, and Developmental Therapy. This exemption will be available until December 31, 2021.
Extensions are limited to the following:

- Evaluations that expired on or after March 1, 2020.

- Prior Authorizations will be extended in 90-day increments from the date the re-evaluation was/is due.

Guidelines for requesting an extension:

A. Provide a copy of the expired or expiring evaluation/prescription to the DDS representative via email.

B. DDS will reply with an email providing you with an extension letter for your records.

C. If a Prior Authorization is needed, you will enclose this letter with your request to eQHealth of the re-evaluation extension. Billing procedures will remain the same.

244.000 Telemedicine for Occupational, Physical, and Speech Therapists and Assistants

In response to the COVID-19 allowable telemedicine services include services provided by licensed occupational, physical, or speech therapists or assistants. These services are available to established patients only.

Parental Consultation is a Covid response service that allows a therapist assistant or therapist to instruct a parent or caregiver on how to use therapeutic equipment or techniques with their child to continue working on therapy goals and objectives. To bill for this service, the therapy assistant or therapist must document that the parent or caregiver was present with a beneficiary. The service must be provided using the appropriate real-time technology that includes both a video and audio component. The originating service requirement is relaxed so that the parent may receive this service from their home.

The service may be provided in 15-minute sessions with a maximum of 8 sessions per month. All services must be prior authorized by eQHealth Solutions. This service and individual therapy services through telemedicine will be available until December 31, 2021.

Individual Therapy Services provided by a licensed Physical Therapist, Occupational Therapist, or Speech Therapist or Assistant allows for continued therapy services for established patients during this time of social distancing.

The technology used must be real-time and include a video and audio component. The sessions are limited to thirty minutes a piece, with a maximum of three (3) sessions per week.

The following services cannot be completed via telemedicine:

A. Evaluations and re-evaluations. However, if an annual evaluation is due during this time, the deadline may be extended until the patient is able to come into the office.

B. Group Therapy Services.

245.000 Telemedicine for Applied Behavioral Analysis (ABA) for BCBA

In response to the COVID-19 allowable telemedicine services includes Applied Behavioral Analysis (ABA) services to established patients only. To allow for continued therapy services for established patients during this time of social distancing, DMS/DDS is lifting the requirement that the beneficiary be located at a healthcare facility (originating site) to receive telemedicine services for the following services only:

- Adaptive behavior treatment provided by a Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D)

- Family adaptive behavior treatment guidance, by a BCBA or BCBA-D

This service through telemedicine will be available until December 31, 2021.

Billing Instructions

All units are prior authorized. To bill for this service, the BCBA must document that the parent or caregiver was present with a beneficiary. The service may be provided at the same rate as the regular "face-to-face" rate. All services must be prior authorized by eQHealth Solutions. When billing for these services you must include all modifiers on the claim. All Therapy claims submitted for Telemedicine must include the GT modifier and (02) as the place of service**.**

BCBA is a licensed clinician that may perform telemedicine under the scope of their license. The sessions are limited to 30 minutes, with a maximum of three (3) sessions per week.

97155 EP
Adaptive behavior treatment provided by a BCBA or BCBA-D. Individual adaptive behavior treatment by BCBA, face-to-face with the patient and may also include caregivers. This includes implementation and modification of treatment the plan. This may also include simultaneous direction of technician.

97156 EP
Family adaptive behavior treatment, provided by a BCBA, face-to-face with parents and/or caregivers. Family sessions should address education of the parents or caregivers on the patient's plan of care, specific objectives, treatment approaches, etc. as they relate to the individual client's ASD symptoms and how to address them in the patient's natural environment.

The following services cannot be completed via telemedicine:

A. Evaluations and re-evaluations. However, if an annual evaluation is due during this time, the deadline may be extended until the patient is able to come into the office.

B. Group ABA Services.

246.000 Telemedicine Autism Waiver

In response to COVID-19 the allowable telemedicine service available under the Autism Waiver is 2024 U3 Individual Assessment/Treatment Plan/Development/Monitoring.

These services through telemedicine will be available until December 31, 2021.

247.000 Well Checks and Attendance Payments for Adult Developmental Day Treatment and Early Intervention Day Treatment

In response to COVID-19, well check services are allowable if the beneficiary is unable to attend the clinic setting. The well check services are not allowable if the beneficiary has attended in person at the clinic at least one day that week. Attendance payments are allowable if a beneficiary attends the clinic in person that day.

Well Check services are available for vulnerable children and adults with developmental disabilities and delays who meet the state-determined medical necessity criteria for the programs.

The service is typically a 15-30-minute check-in visit, either by phone or in the home, that ensures the beneficiaries needs are being met for overall health and well-being, such as their nutritional status, medication regimen and any emerging health issues, while the beneficiary is unable to attend their day treatment program where these activities are part of the daily onsite services provided. The services must be recommended by a physician or other licensed practitioner who must determine the services are medically necessary.

The beneficiaries are eligible to receive two (2) well checks per week, one by telemedicine (including telephone) and one face-to-face. Beneficiaries under age twenty-one (21) may get an extension of benefits upon a showing of medical necessity as determined by the state. The well check may be provided in the home or using telemedicine.

Billing Instructions:

T1027 Family Training and Counseling
T1027 U1 in person, one 30-minute unit encounter for $15.00, place of service (12)
T1027 U2 telephonic (by phone), one 15-minute unit encounter for $7.50, place of service (02).

Providers cannot bill two well checks on the same day.

Beneficiaries are eligible for two well check services a week, so providers can bill either one "face to face" or telephonic. Example: IF U1 is provided and billed on Monday, you cannot provide and bill for U2 on Monday. U2 will have to be provided and billed another day during the week to meet the 2 call per week check in requirement.

Attendance payments are available for beneficiaries who attend the clinic setting.
If a child or an adult attends an EIDT/ ADDT clinic, providers may bill one 15- minute unit encounter for $15.00, Place of Service (49), per beneficiary Monday – Friday. If a beneficiary attends a clinic at least one day during the week, a well check service cannot be billed for that same week.

These services will be available until December 31, 2021.

248.000 Community and Employment Support Waiver

In response to COVID-19 DMS/DDS will temporarily modify provider types to all Qualified Behavioral Health Paraprofessionals employed by Outpatient Behavioral Health Service Agencies to provide Supportive Living Services, including Supplemental Supports to PASSE members.

DMS/DDS further amended the CES Waiver to allow an extension for reassessments and reevaluations for up to one year past the due date; allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings; and allow an electronic method of signing off on required documents such as the person-centered service plan.

These services will be available until December 31, 2021.

250.000 MEDICAID ELIGIBILITY

Centers for Medicaid and Medicare Services (CMS) provided guidance that outlines the allowances States are permitted to use for standards required for both eligibility and enrollment of beneficiaries during the National Health Emergency. The threat is that during the COVID-19 Pandemic, the State and/or beneficiaries may not be able to comply with eligibility

and enrollment procedures regarding timeliness, renewals, asset verification, other verification policies, or change in circumstances, causing Medicaid cases to be denied or close, which will affect the household's access to health care.

The suspension of the following Medical Services Policy Sections is part of the Families First Corona Virus Response Act enhanced FMAP requirement.

Applicable Guidance: Families First Coronavirus Response Act (Public Law 116-127 – March 18, 2020), Section 6008(b)

See also the CMS Families First Coronavirus Response Act – Increased FMAP FAQ (question 6): https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf

251.000 Section A-200 Medicaid Coverage Periods

Medical Services Policy A-200 details the Medicaid coverage periods for eligible beneficiaries. Due to the National Health Emergency coverage periods effected due to ineligibility will be extended; except for closure requested by client, death, out-of-state residence, or incarceration. This policy is suspended until the end of the National Health Emergency.

252.000 Section F-130 Child Support Enforcement Services

Medical Services Policy F-130 has a requirement which mandates a beneficiary to cooperate with the Office of Child Support Enforcement. This requirement is suspended until the end of the National Health Emergency.

253.000 Section F-172 Adjustments of Premiums

Medical Services Policy F-172 requires TEFRA beneficiaries to pay a premium in order to receive coverage. TEFRA premium adjustments and case closures for non-payment of premiums are suspended until the end of the National Health Emergency.

254.000 Section I Renewals

(I-110 Renewal Process; I-200 Families and Individuals (MAGI) Groups Renewal Process (I-210 through I-230); I-300 AABD Eligibility Groups Renewal Process; I-320 Alternate Renewal Processes (I-321 through I-327); and K-106 Reevaluations for Foster Medicaid)
Medical Services Policy listed above addresses renewals, renewal processes and timelines for beneficiaries. Medicaid eligibility renewal processes and timelines have been suspended until the end of the National Health Emergency.

255.500 Section L-120 Continuation of Assistance or Services during the Appeal Process

Medical Services Policy L-120 allows for certain Medicaid category beneficiaries to opt in to continue assistance while the appeal is pending. This continuation of assistance (coverage) will be automatic for those beneficiaries during the public health emergency. This adjustment will be in place until the end of the National Health Emergency.

260.000 MEDICAL SERVICES

260.100 Medicaid Provider Manual Section I

260.101 Provider Enrollment Fingerprint Submission Requirements

Section 141.103 concerning fingerprint submission requirements for high risk providers related to background screening is suspended through date of service December 31, 2021.

With respect to providers not already enrolled with another SMA or Medicare, CMS will waive the following screening requirements under 1135(b)(1) and (b)(2) of the Act, so the state may provisionally, temporarily enroll the providers for the duration of the public health emergency:

A. Payment of the application fee - 42 C.F.R. §455.460

B. Criminal background checks associated with Fingerprint-based Criminal Background Checks - 42 C.F.R. §455.434

C. Site visits - 42 C.F.R. §455.432

D. In-state/territory licensure requirements - 42 C.F.R. §455.412

CMS is granting this waiver authority to allow Arkansas to enroll providers who are not currently enrolled with another SMA or Medicare so long as the state meets the following minimum requirements:

A. Must collect minimum data requirements to file and process claims, including, but not limited to NPI.

B. Must collect Social Security Number, Employer Identification Number, and Taxpayer Identification Number (SSN/EIN/TIN), as applicable, to perform the following screening requirements:

   1. OIG exclusion list

   2. State licensure – provider must be licensed, and legally authorized to practice or deliver the services for which they file claims, in at least one state/territory

C. Arkansas must also:

   1. Issue no new temporary provisional enrollments after the date that the emergency designation is lifted,

   2. Cease payment to providers who are temporarily enrolled within six months from the termination of the public health emergency, including any extensions, unless a provider has submitted an application that meets all requirements for Medicaid participation and that application was subsequently reviewed and approved by Arkansas before the end of the six month period after the termination of the public health emergency, including any extensions, and

3. Allow a retroactive effective date for provisional temporary enrollments that is no earlier than March 1, 2020.

260.102 Telemedicine Originating Site Requirements for Advanced Practice Registered Nurses

Section 105.190, regarding the originating site requirements for services provided to established patients by advanced practice registered nurses is suspended through date of service December 31, 2021.

DMS issues the following guidance and policy related to Nurse Practitioners (NP) use of telemedicine.

Professional Relationship Requirements

Generally, a provider must have an established relationship with a patient before utilizing telemedicine to treat a patient. (See Medicaid Provider Manual § 105.190.) However, DMS has the authority to relax this requirement in case of an emergency. Therefore, DMS is lifting the requirement to have an established professional relationship before utilizing telemedicine for nurse practitioners (NP) under the following conditions through date of service December 31, 2021:

- The NP providing telehealth services must have access to a patient's personal health record maintained by a physician.
- The telemedicine service may be provided by any technology deemed appropriate, including telephone, but it must be provided in real time (cannot be delayed communication).
- Nurse Practitioners may use telemedicine to diagnose, treat, and, when clinically appropriate, prescribe a non-controlled drug to the patient as allowed under their scope of practice.

To bill for these services, please use the appropriate billing procedure code with the "GT" modifier and Place of Service (POS) "02"

Originating Site Requirements

DMS is waiving the originating site requirement for evaluation and management (E&M) services provided to established patients by NPs. This will allow the NP to utilize telemedicine technology, including telephone, when appropriate, to diagnose, treatment and prescribe to patients as allowed by their scope of practice, and while the patient remains in their home. To use telemedicine technology to provide services without an originating site, the following requirements must be met:

- The technology must be real-time (cannot be delayed communications).
- The NP must have access to the patient's medical records.

To bill for these services, please use the appropriate billing codes with the "GT" and Place of Service "02" modifier.

Virtual Patient Check-Ins

To prevent unnecessary travel and office visits, Medicaid is opening the virtual check-in CPT (code G2012) described below through date of service December 31, 2021.

To use the Code G2012 to provide virtual check-in services, meet the following requirements:

- Can be any real-time audio (telephone), or "2-way audio interactions that are enhanced with video or other kinds of data transmission."
- For established patients only.
- To be used for:
  - Any chronic patient who needs to be assessed as to whether an office visit is needed.
  - Patients being treated for opioid and other substance-use disorders.
- Nurse or other staff member cannot provide this service. It must be a clinician who can bill evaluation and management (E&M) services.
- If an E&M service is provided within the defined time frames, then the telehealth visit is bundled with that E&M service. It would be considered pre- or post-visit time and not separately billable.
- No geographic location restrictions for the patient.
- Communication must be HIPAA compliant.

Code	Short Description	Fee
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report E&M services, provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment. Typically, 5-10 minutes of medical discussion.	$13.33

260.103 Telemedicine Originating Site Requirements to Allow Services to a Beneficiary in his or her Home Through Date of Service December 31, 2021

Section 105.190 is suspended for the originating site requirement to allow all providers who can provide telemedicine services to provide those services to a beneficiary in his or her home through date of service December 31, 2021.

An out-of-state physician, nurse practitioner, or physician assistant who is an enrolled provider in Arkansas Medicaid may provide telemedicine services to an Arkansas Medicaid client, including prescribing drugs when clinically appropriate. The provider must follow any applicable requirements, including without limitation requirements of the United States Drug Enforcement Agency (DEA), the Arkansas State Medical Board, and the Arkansas Board of Nursing. It is the understanding of DHS that the DEA has temporarily waived the requirement that out-of-state physicians have an Arkansas DEA registration to prescribe drugs through telemedicine:

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf

Professional Relationship Requirements

Generally, a provider must have an established relationship with a patient before utilizing telemedicine to treat a patient. (See Medicaid Provider Manual § 105.190.) However, DMS has the authority to relax this requirement in case of an emergency. DMS is lifting the requirement to have an established professional relationship before utilizing telemedicine for physicians through date of service December 31, 2021 under the following conditions:

- The physician providing telehealth services must have access to a patient's personal health record maintained by a physician.
- The telemedicine service may be provided by any technology deemed appropriate, including telephone, but it must be provided in real time (cannot be delayed communication).
- Physicians may use telemedicine to diagnose, treat, and, when clinically appropriate, prescribe a non-controlled drug to the patient.

To bill for these services, please use the appropriate billing procedure code with the "GT" modifier and Place of Service (POS) "02"

Originating Site Requirements

DMS is waiving the originating site requirement for evaluation and management (E&M) services provided to established patients by primary care providers. This will allow the physician to utilize telemedicine technology, including telephone, when appropriate, to diagnose, treat and prescribe non-controlled substances to patients while the patient remains in their home. The following requirements must be met to use telemedicine technology to provide services without an originating site:

- The technology must be real-time - cannot be delayed communications
- The physician must have access to the patient's medical records.

To bill for these services, please use the appropriate billing codes with the "GT" and Place of Service "02" modifier.

Virtual Patient Check-Ins

To use the Code G2012 to provide virtual check-in services, the following requirements must be met:

- Can be any real-time audio (telephone), or "2-way audio interactions that are enhanced with video or other kinds of data transmission."
- For established patients only.
- To be used for:
    - Any chronic patient who needs to be assessed as to whether an office visit is needed.
    - Patients being treated for opioid and other substance-use disorders.
- Nurse or other staff member cannot provide this service. It must be a clinician who can bill primary care services.

- If an E&M service is provided within the defined time frames, then the telehealth visit is bundled with that E&M service. It would be considered pre- or post-visit time and not separately billable.

- No geographic location restrictions for the patient.

- Communication must be HIPAA compliant.

Code	Short Description	Fee
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report E&M services, provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment. Typically, 5-10 minutes of medical discussion.	$13.33

261.000 Section II of Medicaid Provider Manuals through 269.000

261.100 Ambulatory Surgical Center Provider Manual—Temporary Enrollment as Hospitals

Sections 210.200(A) and 212.000, regarding the definition of an Ambulatory Surgical Center (ASC) as exclusively furnishing outpatient surgical services to patients not requiring hospitalization, are suspended through date of service December 31, 2021.

The Division of Medical Services (DMS) is allowing Ambulatory Surgical Centers (ASCs) to temporarily enroll as hospitals under certain circumstances to provide acute hospital services to patients as needed during the COVID-19 pandemic.

ASCs that wish to enroll as temporary hospitals must submit a waiver request to CMS. Once that waiver is approved, the ASC must seek a temporary hospital license from the Arkansas Department of Health.

To bill Medicaid as hospital, the ASC must provide that temporary hospital license to Arkansas Medicaid Provider Enrollment. The ASC will receive a temporary Medicaid Provider Number as a hospital and will be able to bill for hospital services. Once the temporary hospital provider number is issued and active, the ASC provider number will be suspended temporarily. All services provided will need to be billed under the hospital provider number.

For guidance on billing services, please contact the DMS Utilization Review Unit at (501) 682-8340.

262.000 Arkansas Independent Assessment Provider Manual—Temporary Use of Phone Assessments and Suspension of Timelines for Reassessments

Section 201.000, concerning periodic assessments for behavioral health and developmentally disabled PASSE members is suspended to allow phone assessments by request only, and to extend initial assessment dates for behavioral health PASSE members. The suspension lasts through date of service December 31, 2021.

Independent Assessments are generally performed by Qualified Assessors in a face-to-face setting with behavioral health and developmentally disabled PASSE members. Due to the

Covid-19 public health emergency, this rule is suspended to allow members to request phone assessments instead for periodic assessments.

Families First Corona Virus Response Act requires states to maintain an individual eligibility for amount, duration, and scope of benefits during the public health emergency BH PASSE Members who do not receive a BH Independent re-assessment within 365 days of their existing BH IA would be transitioned to traditional Medicaid and lose access to care coordination, home and community based and psychiatric residential services.

This rule is suspended to allow to allow members who do not receive a timely reassessment to remain in PASSE.

263.000 Critical Access Hospital Provider Manual, End Stage Renal Disease Manual, Hospital Provider Manual—Use of Swing Beds

Section 212.419, regarding the prohibition of coverage of swing bed services by the Arkansas Medicaid Program is suspended through date of service December 31, 2021.

Arkansas Medicaid will cover Swing Beds (Revenue code 194) at a rate of $400 for the following providers:

- Provider Type 05 - Hospital/Provider Specialty CH - Critical Access Hospital

Provider billing instructions for Swing Beds:

- Claims can be submitted electronic or paper with required attachments
- Attach a cover sheet requesting coverage of Swing Bed in a critical access hospital.
- Revenue Code 194 should be billed for Swing Bed days.
- Bill all dates of service for each month on one claim (there will be separate claims filed for dates of service in different months)
- Bill at the amount of $400 per day.

264.000 Hospital Provider Manuals—Medicaid Utilization Management Program (MUMP) Review

Sections 212.500 through 212.550 concerning prior authorization requirements related to Medicaid Utilization Management Program (MUMP) review for hospital stays greater than four (4) days are suspended through date of service December 31, 2021.

All hospital stays through date of service December 31, 2021 are subject only to retrospective review. This includes transfers between hospitals.

265.000 Outpatient Behavioral Health Services Provider Manual

265.100 Behavioral Health Telemedicine

Sections 252.113 and 252.114 concerning face-to-face treatment requirements are suspended through date of service December 31, 2021. Section 252.117 concerning telemedicine service limitations for beneficiaries age twenty-one (21) and over is suspended through date of service December 31, 2021 along with Section 252.119

concerning telemedicine service limitations related to substance abuse assessments and Section 255.001 concerning face-to-face service requirements for crisis intervention.

DMS is suspending the rules prohibiting telemedicine for Marital/Family Behavioral Health Counseling with or without the Beneficiary being present. By suspending this rule, licensed behavioral health professionals will be able to provide Marital and Family Therapy Services via telemedicine. Any technology deemed appropriate may be used, including telephones, but technology must utilize direct communication that takes place in real-time.

The allowable codes for these rule suspensions:

- Marital/Family Behavioral Health Counseling with Beneficiary Present
    - 90847, U4, GT
    - 90847, U4, U5, GT – Substance Abuse
    - 90847, UC, UK, U4, GT – Dyadic Treatment
    - Place of Service to include 02 Telemedicine
- Marital/Family Behavioral Health Counseling without Beneficiary Present
    - 90846, U4, GT
    - 90846, U4, U5, GT – Substance Abuse
    - Place of Service to include 02 Telemedicine

DMS is suspending the rule limiting Mental Health Diagnosis be conducted via telemedicine to only the adult population over age 21. By suspending this rule, licensed behavioral health professionals will be able to use telemedicine as an allowable mode of service delivery to beneficiaries under the age of 21.

The allowable code for this rule suspension:

- Mental Health Diagnosis
    - 90791, U4, GT
    - Allowable Mode of Delivery- Adults, Youth and Children

DMS is suspending the requirement that substance abuse assessments be conducted face-to-face. By suspending this rule, licensed behavioral health professionals will be able to use telemedicine as an allowable mode of service delivery to provide substance abuse assessments.

The allowable code for this rule suspension:

- Substance Abuse Assessment
    - H0001, U4

DMS is suspending the rule prohibiting telemedicine for Crisis Intervention Services. By suspending this rule, licensed behavioral health professionals will be able to provide Crisis Intervention Services via telemedicine. Technology must utilize direct communication that takes place in real-time.

The allowable billing codes for this rule suspension:

- Crisis Intervention
  - H2011, HA, U4, GT
  - Place of service code 02

266.000 Personal Care Manual—Annual Review and Renewal of Personal Care Service Plans

Section 214.200 concerning annual review and renewal of personal care service plans is suspended through date of service, December 31, 2021.

DHS nurses may extend PCSPs and authorizations based on review of current medical/functional needs. DAABHS nurses will complete an assessment of the beneficiary's current needs and will extend the end dates for qualifying beneficiaries, ensuring continued eligibility for services. PCSP's are living documents and are to be updated as goals and needs are met. During the extension period, the PCSP will continue to be updated to the level of current service needs based on continued phone contact with beneficiary.

267.000 Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manual

267.100 Administration of Monoclonal Antibodies

Division of Medical Services (DMS) is covering administration of monoclonal antibodies through date of service December 31, 2021.

DMS will cover the administration of the following monoclonal antibodies in accordance with the terms set out in this memorandum.

CPT Code	Short Description	Rate	Effective Date
Q0239	BAMLANIVIMAB-XXXX	$0.01	November 9, 2020
M0239	BAMLANIVIMAB-XXXX INFUSION	$309.60	November 9, 2020
Q0243	CASIRIVIMAB AND IMDEVIMAB	$0.01	November 21, 2020
M0243	CASIRI AND IMBDEVI INFUSION	$309.60	November 21, 2020

The patient must have a COVID-19 diagnosis and be considered at high risk for progressing to severe COVID-19 and/or hospitalization. The Arkansas Department of Health (ADH) issued an updated Health Alert through the Health Alert Network (HAN) on November 25, 2020, that outlines the criteria and limitations on use of these monoclonal antibodies. DMS will follow the criteria and limitations outlined in that ADH alert and by the FDA in their Emergency Use Authorizations (EUAs) for the above listed drugs, which can be found here:

EUA for Bamlanivimab - **https://www.fda.gov/media/143603/download**

Patient Fact Sheet - **https://www.fda.gov/media/143604/download**

FDA Frequently Asked Questions -**https://www.fda.gov/media/143605/download**

EUA for Casirivimab and Imdevimab - **https://www.fda.gov/media/143892/download**

Patient Fact Sheet - **https://www.fda.gov/media/143893/download**

FDA Frequently Asked Questions - **https://www.fda.gov/media/143894/download**

267.200 Limitations on Outpatient Laboratory Services, Related to a Covid-19 Diagnosis

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended as to claims for any lab or x-ray services related to a COVID-19 diagnosis through date of service December 31, 2021.

DMS is exempting claims where a patient is diagnosed with COVID-19 from the lab and x-ray benefit limit outlined in Section 225.100 of the Medicaid Provider Manual for physician/Independent Lab/CRNA/Radiation Therapy Centers. If one of the following COVID-19 diagnoses is listed on any diagnosis field/position on the claim, the procedure will not count against the annual $500.00 benefit limit for lab and x-ray for adults over the age of 21:

- A41.89—Other specified sepsis
- O98.511—Other viral diseases complicating pregnancy, first trimester
- O98.512—other viral diseases complicating pregnancy, second trimester
- O98.513—other viral diseases complicating pregnancy, third trimester
- O98.519—other viral diseases complicating pregnancy, unspecified trimester
- O98.52—Other viral disease complicating childbirth
- O98.53—other viral disease complicating the puerperium
- U07.1—COVID-19
- Z03.818—Encounter for observation for suspected exposure to other biological agents ruled out
- Z09—Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z11.59—Encounter for screening for other viral diseases
- Z20.828—Contact with and (suspected) exposure to other viral communicable disease

267.300 Limitations on Outpatient Laboratory services, for COVID-19 Antigen Laboratory Testing with Procedure Code 87426

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended as to claims for COVID-19 antigen laboratory testing using procedure code 87426 through date of service December 31, 2021.

The following procedures codes are available for billing COVID-19 antigen detection testing. These codes will be retroactive to dates of service June 25, 2020, and forward.

Code	Short Description	Fee
87426	Coronavirus AG IA	$45.23

	Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])	

The following provider types may bill for these services:

- Physicians (PT 01, 03 & 69) • Nurse Practitioners (PT 58)
- Rural Health Clinics (PT 29) • Hospitals (PT 05)
- Arkansas Department of Health (PT 30)
- Rehabilitation Centers (PT 26)

Medicaid is exempting these Covid-19 screens from the $500.00 limit on laboratory and x-ray services for beneficiaries over 21 years of age and from requiring a PCP referral.

267.400 Limitations on Outpatient Laboratory Services, for COVID-19 Laboratory Testing with procedure Codes U0001, U0002, U0003, and U0004

Section 225.100(A), regarding limitations on outpatient laboratory services, is suspended for claims for COVID-19 laboratory testing using procedure codes U0001, U0002, U0003, and U0004 through date of service December 31, 2021.

DMS is covering the following laboratory services. The procedure codes described below will be retroactive to dates of service February 6, 2020:

Code	Short Description	Fee
U0001	CDC developed 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel	$35.92
U0002	Non-CDC developed 2019-nCoV Coronavirus, SARS- CoV2/2019-nCoV (COVID-19)	$51.33

The following procedure codes are available for billing “high-through put” COVID-19 diagnostic testing. These codes will be retroactive to dates of service April 14, 2020.

Code	Short Description	Fee
U0003	Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (Coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies	$100.00
U0004	2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies	$100.00

The following provider types may bill for these services:

- Physicians (PT 01 & 03)

- Nurse Practitioners (PT 58)
- Rural Health Clinics (PT 29)
- Hospitals (PT 05)
- Arkansas Department of Health (PT 30)
- Rehabilitation Centers (PT 26)

These codes are appropriate to be billed when at least one (1) of the following symptoms is present and documented on the claim:

- R05: Cough
- R06/02: Shortness of breath
- R50.9: Fever, unspecified

Medicaid is exempting these Covid-19 screens from the $500.00 limit on laboratory and x-ray services for beneficiaries over 21 years of age.

The following diagnosis codes may also be used to bill for a COVID-19 test. These diagnosis codes will be added to all laboratory test claims that are billed for dates of service February 6, 2020 onward:

- A41.89—Other specified sepsis
- O98.511—Other viral diseases complicating pregnancy, first trimester
- O98.512—Other viral diseases complicating pregnancy, second trimester
- O98.513—Other viral diseases complicating pregnancy, third trimester
- O98.519—Other viral diseases complicating pregnancy, unspecified trimester
- O98.52—Other viral disease complicating childbirth
- O98.53—Other viral disease complicating the puerperium
- U07.1—COVID-19
- Z03.818—Encounter for observation for suspected exposure to other biological agents ruled out
- Z09—Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
- Z11.59—Encounter for screening for other viral diseases
- Z20.828—Contact with and (suspected) exposure to other viral communicable disease

268.000 Physician/Independent Lab/CRNA/Radiation Therapy Center Medicaid Provider Manual; Nurse Practitioner; Hospital

268.100 Annual Limitations for Physician and Outpatient Hospital Visits (1) Treatment of COVID-19 by COVID-19 Diagnosis Codes (2) Physician and Nurse Practitioner Visits to Patients in Skilled Nursing Facilities

Sections 225.000 and 226.000 concerning annual limitations for physician and outpatient hospital visits are suspended to allow for additional visits for (1) treatment of COVID-19 as documented by COVID-19 diagnosis codes, and (2) physician and nurse practitioner visits to patients in skilled nursing facilities through date of service December 31, 2021.

DMS is suspending Section 225.000 and 226.000 of the Medicaid Provider Manual for Physician/Independent Lab/CRNA/Radiation Therapy Center. Specifically, physician and hospital visits related to the treatment of COVID-19 will not count in the twelve (12) visit annual limit. To exempt these visits from the limit, the provider must document one of the COVID-19 related diagnosis codes, which can be found at:

https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice- coronavirusfeb-20-2020.pdf.

Physician and Nurse Practitioner (APRN) visits to patients in skilled nursing facilities will not count against the twelve-visit limit for those beneficiaries.

268.200 Places for Delivery of Services by Physicians, Advanced Practice Registered Nurses, and Hospitals for Billing for COVID-19 Screening and Diagnostic Testing at a Mobile (Drive Thru) Clinic (Place of Service 15)

Section 292.210 concerning places for delivery of services provided by physicians, advanced practice registered nurses, and hospitals is suspended to allow for billing for COVID-19 screening and diagnostic testing at a mobile (drive thru) clinic (Place of Service 15) through date of service December 31, 2021.

DMS is allowing certain providers to set up Mobile (“Pop-up”) clinics to screen and test for COVID-19**.**

Specifically, physicians’ clinics, rural health clinics, federally qualified health centers and hospitals may set up Pop-up or drive-thru clinics in remote locations to provide the following services only:

- Screening for COVID-19 (99499, described below)
- Diagnostic Testing for COVID-19 (U0001 & U0002

These services will be billed using the provider’s Medicaid Provider Number and Place of Service Code 15 (Mobile Clinic).

To accommodate screening for COVID-19, DMS is loading the following code:

99499—Unlisted E&M Service to be billed for COVID-19 Screening. The code will be available to the following provider types:

- Physicians
- APRNs

- Rural Health Clinics
- Federally Qualified Health Centers
- Hospitals

This code is not to be used in conjunction with any other E&M or encounter code that may be billed by the provider but only be used to reflect a screening for COVID-19 (i.e., completing a questionnaire and taking temperature). **The rate is $25.00 for each screening.**

269.000 Transportation Provider Manual--Pick-up and Delivery Locations and Physician Certification Prior to Transport by Non-emergency Ground Ambulance

Sections 213.000, 204.000, and 205.000(A)(2) concerning pick-up and delivery locations and physician certification prior to transport by non-emergency ground ambulance are suspended through date of service December 31, 2021.

DMS is suspending the following policies:

A. Section 213.000 of the Medicaid Provider Manual for Transportation:

1. Ground transportation trips by Ambulance providers may be made to any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to:

   a. Any location that is an alternative site determined to be part of a hospital, Critical Access Hospitals (CAH) or Skilled Nursing Facilities (SNF), community mental health centers federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), and any other location furnishing dialysis services outside of the ESRD facility.

B. Sections 204.000 and 205.000(A)(2) of the Medicaid Provider Manual for Transportation:

1. Physician certification does not have to be obtained to transport a beneficiary via non-emergency ground ambulance transport.

270.000 PROVIDER CERTIFICATION

271.000 Pre-Admission Screening for Nursing Facility Residents Potentially MI/DD

42 CFR § 483.20(k) requires pre-admission screening for prospective nursing home residents to identify persons as potentially MI/DD. CMS granted an 1135 waiver for Arkansas waiving pre-admission screening on April 2, 2020. CMS previously had issued a blanket waiver related to pre-admission screening on March 13th. Specifically, the approval of Federal Section 1135 Waiver requests stated:

- Section 1919(e)(7) of the Act allows Level I and Level II assessments to be waived for 30 days. All new admissions can be treated like exempted hospital discharges. After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available.

- Per 42 C.F.R. §483.106(b)(4), new preadmission Level I and Level II screens are not required for residents who are being transferred between nursing facilities (NF). If the NF is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake and transfers with positive Level I screens would require a Resident Review.

- The 7-9-day timeframe for Level II completion is an annual average for all preadmission screens, not individual assessments, and only applies to the preadmission screens (42 C.F.R. §483.112(c)). There is not a set timeframe for when a Resident Review must be completed, but it should be conducted as resources become available.

The 1135 waiver is set to terminate "upon termination of the public health emergency, including any extensions." These processes and procedures will be available until December 31, 2021.

In response to this declaration and waiver, the Department of Human Services suspended parts of two rules of the Procedures for Determination of Medical Need for Nursing Home Services: (1) Rule I to the extent it prohibits facilities from admitting individuals with diagnoses or other indicators of mental illness or developmental disability; and, (2) Rule II to the extent it requires the state to complete a Level 2 assessment for mental illness or developmental disability within seven (7) to nine (9) workdays from the date the mental illness or developmental disability is identified by the initial screening.

By suspending these rules, nursing homes are able to admit individuals with diagnoses or other indicators of mental illness or developmental disability without first getting an assessment and approval by the Division of Provider Services and Quality Assurance, Office of Long-term Care (OLTC), clearing such individuals for placement in the facility. However, prior to admission, the facility must review the individual's information to ensure the facility can meet the individual's medical and behavioral needs.

272.000 Therapeutic Community Direct Service Requirements

DMS is suspending the rule related to Therapeutic Communities level of direct service requirements contained in the Therapeutic Communities Certification Manual.

The rules to be suspended are Therapeutic Community Certification Manual, Sections 113, 114, 115, 116, 118, 119, and 120.

DPSQA and DMS recommends that Therapeutic Communities offer as many direct service hours to beneficiaries as possible in response to COVID-19 staffing issues. It is recommended that professional counseling services be reduced from ten (10) hours per week to three (3) encounters per week, physician services be reduced from two (2) encounters per month to one (1) encounter per month, and QBHP intervention services be reduced from forty-two (42) hours per week to eighteen (18) hours per week.

These services will be available until December 31, 2021.

280.000 SNAP

The Supplemental Nutrition Assistance Program (SNAP) guidance that has been provided by Food and Nutrition Services (FNS) outlines the allowances States are permitted to use for standards for both eligibility and enrollment of recipients and the operation of the State Agency. The COVID-19 pandemic has altered the standard procedures of the Agency and

has affected the compliance processing standards of the Agency and its recipients. The suspension of the following SNAP policy sections is in response to the National Health Emergency.

Applicable Guidance: Families First Coronavirus Response Act (Public Law 116-127 – March 18, 2020) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

281.000 Quality Control

DHS conducts quality control reviews of cases monthly to determine if any variance exists between what the reviewer has gathered about the case versus what the county office used to determine eligibility or denial. The Quality Control reviewers are required to conduct field reviews to obtain information from the household regarding their actual circumstances. The field reviews include interviews with the household and collateral contacts. In response to the National Public Health emergency, the Division of County Operations (DCO) has suspended face-to-face interviews.

This suspension will end at the conclusion of the national health emergency unless the regulating agency (FNS) ends suspension earlier.

282.000 Provision for Impacted Students

The Supplemental Nutrition Assistance Program (SNAP) describes the criteria that students must meet to be eligible for the program. A household member who is enrolled in an institution of higher education or an institution of post-secondary education is defined a student. Students are eligible to participate in SNAP if they:

A. Meet employment criteria

B. Are approved to participate in a state or federally financed work-study program.

C. Are responsible for the care of a dependent under the age of six or under the age of 12 if adequate childcare is unavailable or if the student is unable to meet the employment criteria due to caring for the child.

D. Are receiving TEA Benefits, or

E. Participating in an on-the-job training program

283.000 Recertification Interviews

Households that submit a timely Application for Recertification must be interviewed before the end of their current certification period. The household will be scheduled a telephone interview unless the household requests a face-to-face interview. In response to the National Health Emergency, the interview requirement for recertification applications is suspended.

This adjustment will end at the conclusion of the national health emergency unless the regulating agency (FNS) ends adjustment earlier.

284.000 Work Participation for Abled-Bodied Adults Without Dependents

Abled-Bodied Adults without Dependents are ineligible to receive SNAP benefits beyond a three-month period unless they meet the following criteria:

A. Work at least 20 hours per week

B. Participate and comply with a Workforce Investment Opportunities Act (WIOA)

C. Participate and comply with SNAP Employment and Training Program

D. Participate in and comply with a Workfare Program

E. Participate at least half-time in a recognized refugee training program operated by the Office of Refugee Resettlement (ORR).

The Families First Coronavirus Response Act, March 2020, allowed flexibilities to states to grant good cause to individuals who were not able to comply with work requirements due to the public health emergency. In response to the National Health Emergency, DCO has suspended the work requirements for this group until the Secretary of the United States Department of Agriculture declares the National Public Health Emergency has ended.

Applicable Guidance: Families First Coronavirus Response Act (Public Law 116-127 – March 18, 2020)

285.000 Supplemental Benefits

Supplemental SNAP benefits are issued to a household to correct errors made by the agency or the automated system.

In response to the national public health emergency, and provisions made in the Families First Coronavirus Response Act of 2020 (FFCRA), the agency will grant the maximum benefit amount the SNAP participants based on their household size.

These benefits remain as long as both the National Public Health Emergency and State Public Health Emergency are in effect. The benefits end upon conclusion of either emergency.

290.000 TEA

The Administration of Children and Families (ACF) provided guidance to States outlining broad flexibility for adjustments to the TANF program due to the National Health Emergency. This guidance allows the States to make eligibility and enrollment adjustments for TANF applicants and recipients to be less burdensome. This is due to the extensive requirements to maintain eligibility or become eligible in TANF as households were affected by the National Health Emergency.

291.000 Section 2004 Application Interview and Section 2004.1 Personal Responsibility Agreement

TEA Policy Section 2004 and 2004.1 addresses TEA interviews and the requirement that TEA interviews be face to face with the applicant. Due to the National Health Emergency, telephone interviews are allowed regardless of the application origins (paper or online). This suspension will remain until the end of the National Public Health Emergency.