

Division of Medical Services (DMS)
COVID-19 Response Manual

March 11, 2022

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200.000 OVERVIEW

201.000 Authority

The following rules are duly adopted and promulgated by the Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) under the authority of Arkansas Code Annotated §§ 20-76-201 20-77-107, 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-19 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.

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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever comes first.

With respect to providers not already enrolled with another State Medicaid Agency or Medicare, DMS will waive the following screening requirements so the state may temporarily enroll the providers for the duration of the public health emergency or until December 31, 2022, whichever occurs first:

- 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

The Centers for Medicare and Medicaid Services (CMS) is granting 1135 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.

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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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 individuals with developmental disabilities 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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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 AND IDD PASSE Members who do not receive a BH or IDD Independent re-assessment within 365 days

of their existing BH AND IDD 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 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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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

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

Provider billing instructions for Swing Beds:

- Claims can be submitted electronically or by 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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

Through the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first, all hospital stays are subject only to retrospective review. This includes transfers between hospitals.

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 (PCSPs) is suspended through the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

DHS nurses may extend PCSPs and authorizations based on review of current medical/functional needs. Division of Aging and Adult Service and Behavioral Health Services (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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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 the

termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

The following procedures codes are available for billing COVID-19 antigen detection testing.

Code	Short Description	Fee
87426	Coronavirus AG IA Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or	\$45.23

	semiquantitative, multiple-step method; severe acute respiratory syndrome coronavirus (e.g., SARS-CoV, SARS-CoV-2 [COVID-19])	
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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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

DMS is covering the following laboratory services:

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:

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:

- 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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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-Guidance-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

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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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, 87426)

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 (PT 01 & 03)
- APRNs (PT 58)
- Rural Health Clinics (PT 29)
- Federally Qualified Health Centers (PT 49)
- Hospitals (PT 05)

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 the termination of the federal public health emergency, including any extensions, or December 31, 2022, whichever occurs first.

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 COVID-19 Vaccination Administration for Home-Bound Medicaid Clients

Division of Medical Services (DMS) is covering administration of COVID-19 vaccination shots for home-bound Medicaid clients through the end of the Federal Public Health Emergency. This section will affect Home Health and Pharmacy provider types, and the policies herein are in addition to current policies.

Authorized Providers

The following Arkansas Medicaid providers will be authorized to administer COVID-19 vaccinations in a Medicaid client's home or similar location:

- Home Health Providers (Provider Type 14); and
- Pharmacy Providers (Provider Type 07/PV)

Eligibility and Place of Service

The following eligibility and place of service requirements apply to this service for Home Health providers:

- For Medicaid clients who currently receive Home Health services:
 - If the Medicaid client is currently receiving Home Health services for prior medical services, the Home Health provider may bill the vaccination administration in addition to the Home Health visit.
 - A Home Health provider may not charge for a Home Health visit if the vaccine administration is the sole medical service provided.
 - Visits for Covid Vaccine administration will not count against the fifty-visit Home Health visit limit.
- For Medicaid clients who do not currently receive Home Health services:
 - Admission to the Home Health Services program is not required for visits that are solely to administer the COVID-19 vaccination.
 - Examples of Medicaid clients eligible for this service can include those who face barriers or challenges to obtaining a COVID-19 vaccination and who might not get vaccinated without this service being provided in their home by Medicaid Home Health providers. The Centers for Medicare & Medicaid Services (CMS) created an [infographic](#) to help Medicare providers understand the scope of this service, which Medicaid providers may find helpful.
 - The basis for eligibility must be documented by the Home Health provider.

Required Recordkeeping

All providers should maintain accurate records for auditing purposes.

For this program, Home Health or Pharmacy Providers are required to maintain at least the following documentation in their records.

- **Eligibility:** Home Health or Pharmacy providers must document the Medicaid client's eligibility for the Home Health service, including without limitation:
 - The client's clinical status; and
 - The barriers faced by the client to get the vaccine outside the home.
- **Clinical Information:** Home Health or Pharmacy providers must:
 - Have and maintain a record of the physician order, vaccine administration, and how the vaccine was tolerated; and

- Communicate vaccinations to the appropriate entity that will record vaccinations in the vaccine registry.

Billing Guidelines and Payment of Claims

- Single Medicaid Client: The claim for a single Medicaid client’s home (or similar location) vaccine administration is limited to one (1) time per home or location per date of service (DOS). The timeframes between vaccination shots must be adhered to.
- Multiple Medicaid Clients: If the vaccination is being administered in a group-living location where fewer than ten (10) Medicaid clients reside, up to five (5) vaccine administration claims are allowed in that home or communal space location per DOS.
- Home Health and Pharmacy providers may file eligible claims for the vaccination doses included in this Official Notice for three-hundred and sixty-five (365) days from the DOS.

Covered Vaccinations, Procedure Codes, and Rates

The section applies to the first, second, and third doses of the Pfizer and Moderna vaccines and the single-shot Johnson & Johnson vaccine and booster(s).

The reimbursement rate for vaccine administration fee is based on the DOS that the COVID-19 vaccine medicine is provided.

The effective date for **home administration** of COVID-19 vaccinations (all shots) and the procedure code that must be used is:

Procedure Code	Description	Effective Date	Rate
M0201	Covid-19 vaccine administration inside a patient's home	November 11, 2021	\$35.50

This procedure code must be reported **in addition to** the correct procedure code for the product and dose-specific Covid Vaccine medication administration procedure code.

Guidance for Home Health Vaccine Administration

The [Centers for Disease Control and Prevention \(CDC\)](#) and CMS issued guidelines to assist Home Health providers in administering in-home COVID-19 vaccinations:

- [Vaccinating Homebound Persons with COVID-19 Vaccine | CDC](#)
- [COVID-19 Vaccine FAQs for Healthcare Professionals | CDC](#)
- [Medicare COVID-19 Vaccine Shot Payment | CMS](#)

Official Notice for this allowed Service

Providers should see Official Notice ON-014-21 for information.