Division of Medical Services
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MEMORANDUM

TO: Interested Persons and Providers

FROM: Elizabeth Pitman, Director, Division of Medical Services

DATE: April 9, 2024

SUBJ: Obstetric Professional Rate Increase and Unbundling

As a part of the Arkansas Administrative Procedure Act process, attached for your review and comment are proposed rule revisions.

Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.
If you have any comments, please submit those comments no later than May 10, 2025.

All DHS proposed rules, public notices, and recently finalized rules may also be viewed at: Proposed Rules & Public Notices.

NOTICE OF RULE MAKING

The Department of Human Services (DHS) announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§20-76-201, 20 77-107, and 25-10-129. The proposed effective date of the rule is July 1, 2025.

The Department of Humans Services (DHS) seeks to revise the rate and claims process for prenatal, delivery, and postpartum professional services under Medicaid pursuant to Acts 124 and 140 of 2025, known widely as "Healthy Moms, Healthy Babies". The goal of the rate and claims revision is to improve Medicaid reimbursement to ensure adequate access to care and to improve Medicaid's data collection on utilization of prenatal and postpartum services. DHS will submit a state plan amendment (SPA) to the Centers for Medicare & Medicaid (CMS) to implement the new rate and claims process. Implementation also requires updates to the Certified Nurse Midwife, Federally Qualified Health Center, Nurse Practitioner, Physician, and Rural Health Center Medicaid provider manuals. The proposed rule estimates a financial impact of $38,030,852.00 per fiscal year (State $11,702,093; Federal $26,328,759).

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

Public comments can be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than May 10, 2025. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

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

If you need this material in a different format, such as large print, contact the Office of Policy and Rules at 501-320-6428.

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and is operated, managed and delivers services without regard to religion, disability, political affiliation, veteran status, age, race, color, or national origin.
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Elizabeth Pitman, Director
Division of Medical Services

TOC required

213.600 Certified Nurse-Midwife Services Benefit Limit

~~3-15-10~~7-1-25

Beneficiaries age twenty-one (21) and older are limited to ~~twelve~~ sixteen (1~~2~~6) visits per state fiscal year (July 1 through June 30) for services provided by a certified nurse-midwife, physician's services, rural health clinic services, medical services furnished by a dentist, office medical services by an optometrist, services provided by an advanced nurse practitioner, or a combination of the six.

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

The following services are counted toward the sixteen (1~~2~~6) visits per state fiscal year limit established for the Certified Nurse-Midwife Program:

A. Certified nurse-midwife services

B. Physician services in the office, patient's home, or nursing facility

C. Rural health clinic (RHC) core services

D. Medical services provided by a dentist

E. Medical services furnished by an optometrist

F. Advanced nurse practitioner services

~~Global obstetric fees are not counted against the 12 visit limit. Itemized obstetric office visits are counted in the limit.~~Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. ~~-~~Refer to Section 214.000 of this manual for procedures for obtaining extension of benefits.

Beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

240.100 Procedure for Obtaining Prior Authorization

7-1-~~20~~25

A. Certain medical and surgical procedures are not covered ~~only when~~without prior authorization~~ed because of~~due to federal requirements, or because of the elective nature of the surgery. ~~-~~**View or print the procedure codes for Certified Nurse Midwife (CNM) services for a listing of codes and requirements.**

B. DHS or its designated vendor issues prior authorizations for restricted medical and surgical procedures covered by the Arkansas Medicaid Program. ~~-~~**View or print contact information**~~-~~ to obtain the DHS or designated vendor step-by-step process for requesting prior authorizations.

~~B~~1. Prior authorization determinations are in accordance with established medical ~~and~~or administrative criteria combined with the professional judgment of physician advisors.

2. Payment for prior-authorized services is in accordance with federal regulations.

C. Prior authorization of services does not guarantee eligibility for a beneficiary. Payment is subject to verification that the beneficiary is Medicaid-eligible at the time services are provided. ~~Written documentation is not required for prior authorization. However, the patient's records must substantiate all information given. Any retrospective review of a case will rely on the written record.~~

D. It is the responsibility of the certified nurse-midwife who will perform the procedure to initiate the prior authorization request. ~~-~~An electronic portal and training are available to submit requests to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization.**

E. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.

F. Consulting physicians or practitioners are responsible for having DHS or its designated vendor add their required or restricted procedures to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

~~The following specific information must be furnished: (**If request is made by phone, all calls will be tape recorded.**)~~

~~1. Patient Name and Address;~~

~~2. Beneficiary Medicaid Identification Number;~~

~~3. Certified Nurse-Midwife Name and License Number;~~

~~4. Certified Nurse-Midwife Medicaid Provider Number;~~

~~5. Hospital Name; and~~

~~6. Date of Service for Requested Procedure.~~

~~The caller must provide **all** patient identification information and medical information related to the necessity of the procedure.~~

~~If surgery is involved, a copy of the authorization will be sent to the hospital where the service will be performed. If the hospital has not received a copy of the authorization before the time of admission, the hospital will contact the admitting certified nurse-midwife or DHS or its designated vendor to verify that prior authorization has been granted.~~

~~**It is the responsibility of the primary surgeon to distribute a copy of the authorization to the assistant surgeon if the assistant has been requested and approved. The Medicaid Program will not pay for inpatient hospital services that require prior authorization if the prior authorization has not been requested and approved.**~~

~~Consulting physicians are responsible for having their required or restricted procedures added to the PA file. A letter verifying the PA number will be sent to the consultant upon request.~~

~~Post-authorization will be granted only for emergency procedures or for services provided to a Medicaid beneficiary during a period of retroactive eligibility. Requests for emergency procedures must be made no later than the first working day after the procedure has been performed. In cases of retroactive eligibility, the provider must contact DHS or its designated vendor for post-authorization within sixty (60) days of the eligibility authorization date. **View or print contact information**.~~

240.110 Post-Procedural Authorization Process **7-1-~~06~~25**

When a provider is unable to submit a request for required authorization prior to providing a service, a post-procedural authorization process must be followed to obtain an authorization number:

A. All requests for post-procedural authorizations for eligible beneficiaries are to be made to DHS or its designated vendor. **View or print contact information to obtain the DHS or designated vendor step-by-step process for requesting prior authorization**.

B. Out-of-state providers and others without electronic capability may call DHS or its designated vendor to obtain the dates of eligibility. **View or print contact information to obtain dates of eligibility.**

C. The provider must supply the identifying criteria for the beneficiary and provider and all medical data necessary to justify the procedures.

D. Consulting physicians or practitioners are responsible for having DHS or its designated vendor add their required or restricted procedures to the PA file. They will be given the prior authorization number at the time of contact on cases that are approved.

240.120 Post-Procedural Authorization Process for Beneficiaries who are Under Age 21 7-1-25

Providers performing surgical procedures that require prior authorization for beneficiaries under age twenty-one (21) are allowed sixty (60) days from the date of service to obtain a prior authorization number. ~~Providers must follow the post-procedural authorization process when obtaining an authorization number for the procedures listed in Section 213.500.~~

240.130 Post-Procedural Authorization for Beneficiaries Aged 21 and Older 7-1-25

~~All requests for post-procedural authorizations for eligible beneficiaries are to be made to the Arkansas Foundation for Medical Care (AFMC) by telephone within 60 days of the date of service. These calls will be tape-recorded.~~ **View or print AFMC contact information.**

~~The beneficiary and provider identifying criteria and all of the medical data necessary to justify the procedures must be provided to AMFC.~~

~~As medical information will be exchanged for the previously performed procedures, these calls must be made by the certified nurse-midwife or a nursing member of his or her staff.~~

~~The provider will be issued a PA number at the time of the call if the procedure requested is approved. A follow-up letter will be mailed to the certified nurse-midwife on the same day.~~

~~The Arkansas Medicaid Program continues to recommend that providers obtain prior authorization for procedures requiring prior authorization in order to prevent risk of denial due to lack of medical necessity.~~

For beneficiaries aged twenty-one (21) and older, post-procedural authorization will be granted only for emergency procedures and in cases of retroactive eligibility. Requests for post-authorization of an emergency procedure must be submitted on the first business day after the procedure is performed.

In cases of retroactive eligibility, the provider must submit the request for post-authorization within sixty (60) days of the eligibility authorization date displayed in the electronic eligibility verification response.

240.200 Prescription ~~Drug~~ Prior Authorization ~~10-13-03~~7-1-25

Prescription drugs are available for reimbursement under the Arkansas Medicaid Program ~~pursuant to an order from an authorized prescriber~~ when prescribed by a certified nurse midwife with prescriptive authority. ~~A pharmacy must have prior authorization before dispensing certain drugs~~Certain prescription drugs may require prior authorization. ~~I~~It is the responsibility of the prescriber to request and obtain the prior authorization. ~~Refer to the Arkansas Medicaid website at **https://medicaid.mmis.arkansas.gov/** for the following information:~~ Information may be

obtained from DHS or its designated vendor. **View or print contact information for DHS or designated prescription drug vendor**.

The following information is available through DHS or the designated prescription drug vendor:

A. Prescription drugs requiring prior authorization.

B. Criteria for drugs requiring prior authorization.

C. Forms to be competed for prior authorization.

D. Procedures required of the prescriber to request and obtain prior authorization.

272.470 Newborn Care

~~2-1-22~~7-1-25

All newborn services must be billed under the newborn's own Medicaid identification number. ~~midwife can refer interested individuals to the Department of Human Services through the~~ The parent(s) of the newborn will be responsible for applying for and meeting eligibility requirements for a newborn to be certified eligible. The hospital/physician/certified nurse-midwife can refer interested individuals to the Department of Human Services through the Hospital/Physician/Certified Nurse-Midwife Referral Program. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

View or print the procedure codes for Certified Nurse Midwife (CNM) services.

For routine newborn care following a vaginal delivery or C-section, procedure code should be used one time to cover all newborn care visits. Payment of these ~~codes~~ newborn services is considered a global rate, and subsequent visits may not be billed in addition ~~to~~. These codes include the physical exam of the baby and the conference(s) with the newborn's parent(s)~~,~~ and are considered to be the initial Child Health Services (EPSDT) screen. Routine newborn care is exempt from the PCP requirement.

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

For illness care (e.g., neonatal jaundice), use procedure codes. Do **not** bill in addition to these codes.

For newborn resuscitation, **use the appropriate procedure code as listed within the linked table**.

~~May be billed on the CMS-1500 claim form or on the electronic claim transaction format. These codes may also be filed on the CMS-1500; paper or electronically for ARKids A beneficiaries. For ARKids B beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center.~~ **~~View or print the Provider Assistance Center contact information.~~**

~~For ARKids A (EPSDT) – Requires a CMS-1500 claim form; may be billed electronically or on paper.~~

~~For ARKids First B – Requires a CMS-1500 claim form; may be billed electronically or on paper.~~

ARKids A and ARKids B beneficiary services require a CMS 1500 claim form and may be filed electronically or on paper. Please note the processing time for paper claims is extended for manual processing.

For ARKids B-beneficiaries, newborn screening codes must be billed electronically or on the paper CMS-1500 claim form. For information, call the Provider Assistance Center. **View or print the Provider Assistance Center contact information**.

See Sections 241.000 – 243.310 of the EPSDT manual for specific EPSDT billing instructions.

272.490 Obstetrical Care

~~10-13-03~~7-1-25

~~There are two methods of billing for obstetrical care: (1) Global—All-Inclusive Rate (See Section 272.491) or (2) Itemized Billing (See Section 272.492).~~Providers should bill for prenatal, delivery, and postpartum services separately. Effective July 1, 2025, and thereafter, global obstetrical billing is not payable.

~~272.491 Method 1 – "Global" or "All-Inclusive" Rate~~

~~2-1-22~~

~~A. One charge for total obstetrical care is billed. The single charge would include the following:~~

~~1. Antepartum care, which includes:~~

~~a. initial and subsequent history~~

~~b. physical examinations~~

~~c. recording of weight~~

~~d. blood pressure~~

~~e. fetal heart tones~~

~~f. routine chemical urinalyses~~

~~g. maternity counseling~~

~~h. office visit charge when diagnosis is pregnancy related~~

~~2. Admission to the hospital. All admissions and subsequent hospital visits for the treatment of false labor.~~

~~3. Delivery - vaginal delivery (with or without episiotomy, with or without forceps or breech delivery) and resuscitation of newborn infant when necessary.~~

~~4. Postpartum care, which includes hospital and office visits following vaginal delivery.~~

~~B. The global method must be used when the following conditions exist:~~

~~1. At least two months of antepartum care were provided culminating in delivery.~~

~~2. The patient was continuously Medicaid eligible for at least two months before delivery.~~

~~If either condition is not met, the claim will be denied. The denial will state either "monthly billing required" or "beneficiary ineligible for service dates."~~

~~C. When billing for global care, procedure code must be used.~~

~~View or print the procedure codes for Certified Nurse Midwife (CNM) services.~~

~~The provider should indicate in the date of service field of the claim form:~~

~~1. The first date of antepartum care after Medicaid eligibility has been established~~

~~2. The date of delivery~~

~~3. If these two dates are not entered and are not at least two months apart, payment will be denied. The filing deadline will be calculated based on the date of delivery.~~

~~D. No benefits are counted against the beneficiary's annual office visit benefit limit if the global method is used.~~

~~E. The global method of billing should be used when one or more certified nurse-midwives in a group sees the patient for one or more prenatal visits. The certified nurse-midwife who~~

~~delivers the baby should be listed as the attending provider on the claim for global obstetric care.~~

~~272.492 Method 2 – "Itemized Billing"~~ ~~2-1-22~~

~~Itemized billing must be used when the following conditions exist:~~

~~A. Less than two months of antepartum care was provided.~~

~~B. The patient was NOT Medicaid eligible for at least the last two months of the pregnancy.~~

~~C. If Method 2 is used to bill OB services, care should be taken to ensure that the services are billed within the 12-month filing deadline.~~

When billing obstetrical services, ~~V~~**view or print the procedure codes for Certified Nurse Midwife (CNM) services**.

~~D. If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure code should be billed for vaginal delivery. Procedure codes may not be billed in addition to procedure code. These procedures will be reviewed on a post-payment basis to ensure that they are not billed in addition to antepartum or postpartum care.~~

~~E.~~ Providers may bill laboratory and X-ray services separately using the appropriate CPT procedure codes if this is the certified nurse-midwife's standard office practice.

~~1~~A. When lab tests ~~and/~~or x-rays are pregnancy related, the referring certified nurse-midwife must be sure to code appropriately when these services are sent to the lab or x-ray facility. The diagnostic facilities are completely dependent on the referring certified nurse-midwife for diagnosis information necessary for reimbursement.

~~2~~B. The obstetrical laboratory profile procedure code consists of four components: ~~-~~complete blood count, VDRL, Rubella and blood typing with RH. ~~-~~If the ASO titer is performed, the test should be billed separately using the individual code.

~~3~~C. As with any laboratory procedure, if the specimen is sent to an outside laboratory, only a collection fee may be billed. ~~-~~The laboratory may then bill Medicaid for the laboratory procedure. ~~-~~Refer to Section 272.450 of this manual.

NOTE: Payment will not be made for emergency room certified nurse-midwife charges for an OB patient admitted directly from the emergency room into the hospital for delivery.

Certified nurse-midwives must use the appropriate procedure code with modifier **UA** to bill for one to three visits for ~~antepartum~~prenatal care ~~without delivery~~.

~~P~~The appropriate procedure code with no modifier must be used by providers to bill four to six (6) visits for ~~antepartum~~prenatal care without delivery~~,~~ and the appropriate ~~P~~procedure code with no modifier is to be used for seven (7) or more visits without delivery.

View or print the procedure codes for Certified Nurse Midwife (CNM) services to identify which procedure codes are allowable.

~~This enables certified nurse-midwives rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for their services provided.~~ Coverage for this service will include routine sugar and protein analysis. ~~-~~One unit equals one visit. ~~-~~Units of service billed with this procedure code will not be counted against the patient's office visit benefit limit.

Providers must enter the "from" and "through" dates of service on the claim and the number of units being billed. ~~-~~One visit equals one unit of service. ~~-~~Providers must submit the claim within 12 months of the first date of service.

For example: An OB patient is seen by the certified nurse-midwife on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another provider prior to the delivery. The certified nurse-midwife may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. This claim must be received by the Arkansas Medicaid fiscal agent prior to twelve (12) months from 1-10-05 to fall within the 12-month filing deadline. The certified nurse-midwife must have on file the patient's medical record that reflects each date of service being billed.

TOC not required

220.000 Benefit Limits

~~2-1-24~~7-1-25

A. Arkansas Medicaid clients aged twenty-one (21) and older are limited to sixteen (16) FQHC core service encounters per state fiscal year (SFY, July 1 through June 30).

The following services are counted toward the sixteen (16) encounters per SFY benefit limit:

1. Federally Qualified Health Center (FQHC) encounters;
2. Physician visits in the office, patient's home, or nursing facility;
3. Certified nurse-midwife visits;
4. RHC encounters;
5. Medical services provided by a dentist;
6. Medical services provided by an optometrist; and
7. Advanced practice registered nurse services in the office, patient's home, or nursing facility.

B. The following services are not counted toward the sixteen (16) encounters per SFY benefit limit:

1. FQHC inpatient hospital visits do not count against the FQHC encounter benefit limit. Medicaid covers only one (1) FQHC inpatient hospital visit per Medicaid-covered inpatient day, for clients of all ages.
2. Obstetric and gynecologic procedures reported by CPT surgical procedure code do not count against the FQHC encounter benefit limit.
3. Postpartum visits are to be billed as an encounter, with an appropriate postpartum diagnosis code. These will not count against the FQHC encounter benefit limit.
4. ~~3~~ Family planning surgeries and encounters do not count against the FQHC encounter benefit limit.
5. ~~4~~ Medication Assisted Treatment for Opioid Use Disorder does not count against the FQHC encounter limit when it is the primary diagnosis (**View ICD OUD Codes**).

C. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program are not subject to an FQHC encounter benefit limit.

TOC not required

214.210 Advanced Practice Registered Nurse (APRN) Services Benefit Limits

7-1-252

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

The following services are counted toward the Service Benefit Limits established for the state fiscal year:

1. APRN services in the office, patient's home, or nursing facility
2. Physician services in the office, patient's home, or nursing facility
3. Rural health clinic (RHC) encounters
4. Medical services furnished by a dentist
5. Medical services furnished by an optometrist
6. Certified nurse-midwife services
7. Federally qualified health center (FQHC) encounters

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

~~Global obstetric fees are not counted against the visit limit. Itemized obstetric office visits are not counted in the limit.~~Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

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

TOC required

247.000 Obstetrical Services

~~3-15-05~~7-1-25

The Arkansas Medicaid Program covers obstetrical services for Medicaid-eligible beneficiaries. These services include prenatal services, delivery, and postpartum care. ~~-~~Please refer to Sections 292.670 through 292.675~~6~~ of this manual for special billing instructions for pregnancy-related services.

292.670 Obstetrical Care

~~10-13-03~~7-1-25

~~There are two methods of billing for obstetrical care.~~

Medicaid reimburses obstetrical care on a fee-for-service basis.

~~292.671 Method 1 - "Global" or "All-Inclusive" Rate~~

~~2-1-22~~

~~The global method of billing should be used when one (1) or more physicians in a group see the patient for a prenatal visit and one (1) of the physicians in the group does the delivery. The physician that delivers the baby should be listed as the attending physician on the claim that reflects the global method.~~

~~No benefits are counted against the beneficiary's physician visit benefit limit if the global method is billed.~~

~~A. One (1) charge for total obstetrical care is billed. The single charge includes the following:~~

~~1. Antepartum care which includes initial and subsequent history, physical examinations, recording of weight, blood pressure, and fetal heart tones, routine chemical urinalyses, maternity counseling, and other office or clinic visits directly related to the pregnancy.~~

~~2. Admissions and subsequent hospital visits for the treatment of false labor, in addition to admission for delivery.~~

~~3. Vaginal delivery (with or without episiotomy, with or without pudendal block, with or without forceps, or breech delivery), or cesarean section and resuscitation of newborn infant when necessary.~~

~~4. Routine postpartum care (sixty (60) days), which includes routine hospital and office visits following vaginal or cesarean section delivery.~~

~~B. The global method must be used when the following conditions exist:~~

~~1. At least two (2) months of antepartum care were provided culminating in delivery. The global billing beginning date of service is the date of the first visit that a Medicaid beneficiary is seen with a documented possible pregnancy or a confirmed pregnancy diagnosis. This beginning date of service must be billed in the "initial treatment date" field on the claim when billing for global obstetric care.~~

~~2. The patient was continuously Medicaid eligible for two (2) months or more months before delivery and on the delivery date.~~

~~If either of the two (2) conditions is not met, the services will be denied, stating either "monthly billing required" or "beneficiary ineligible for service dates".~~

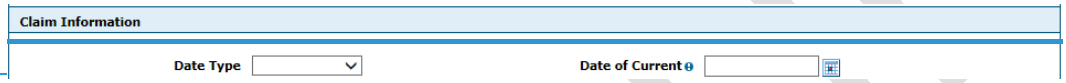
~~C. The correct codes for billing Medicaid for global obstetric care are as follows.~~

~~View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.~~

~~When billing these procedure codes, both the first date of antepartum care after Medicaid eligibility has been established and the date of delivery must be indicated on the claim. The delivery date is the date that is to be in the From and To Date of Service billed on the line with the above codes. The first date of antepartum care is to be billed in the "Initial Treatment Date" field.~~

~~For the CMS 1500 claim form, this is field 15 – Other Date Field. Qualifier 454 is required.~~

~~For the Provider Portal, the Date Type is "Initial Treatment Date" and the Date of Current is the first date of antepartum care.~~



~~If these two (2) dates are not entered and are not at least two (2) months apart, payment will be denied. The 12-month filing deadline is calculated based on the date of delivery.~~

~~292.672 Method 2 - "Itemized Billing"~~ ~~2-1-22~~

~~Use this method only when either of the following conditions exists:~~

~~A. Less than two months of antepartum care was provided~~

~~B. The patient was NOT Medicaid eligible for at least the last two (2) months of the pregnancy.~~

~~Bill Medicaid for the antepartum care in accordance with the special billing procedures set forth in Section 292.675. The visits for antepartum care will not be counted against the patient's annual physician benefit limit. Date-of-service spans shall not include any dates for which the patient was ineligible for Medicaid.~~

Providers should bill for prenatal, delivery, and postpartum services separately. Effective July 1, 2025, and thereafter, global obstetrical billing is not payable.

Providers may ~~B~~bill Medicaid for the delivery and postpartum care with the applicable procedure code~~s~~ from the following table:

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

Non-emergency hysterectomy after C-section requires prior authorization from DHS or its designated vendor. ~~-~~**View or print contact information to obtain the DHS or designated vendor step-by-step process for prior authorization requests.** ~~-~~Refer to Section 292.580 for billing instructions for emergency and non-emergency hysterectomy after C-section.

~~If Method 2 is used to bill for OB services, p~~Providers must ensure that the services are billed within the 365-day filing deadline.

~~If only the delivery is performed and neither antepartum nor postpartum services are rendered, procedure codes must be billed for vaginal delivery and procedure codes must be billed for cesarean section. Procedure codes shall not be billed in addition to procedure codes. These procedures will be reviewed on a post-payment basis to ensure that these procedures are not billed in addition to antepartum or postpartum care.~~

Laboratory and X-ray services may be billed separately using the appropriate CPT codes. ~~if this is the physician's standard office practice for billing OB patients.~~ If lab tests or X-rays are pregnancy related, the referring physician must code correctly when these services are sent to the lab or X-ray facility. The diagnostic facilities are ~~totally~~ dependent on the referring physician for pregnancy related diagnosis information necessary for Medicaid reimbursement.

The obstetrical laboratory profile procedure code consists of four components: Complete Blood Count, VDRL, Rubella, and blood typing and RH. If the ASO titer is performed, the test must be billed separately using the individual code.

~~Only a collection may be filled for laboratory procedures, i~~If a blood specimen is sent to an outside laboratory, only ~~a~~ one collection fee may be billed. No additional fees shall be billed for other types of specimens that are sent for testing to an outside laboratory. The outside laboratory may then bill Medicaid for the laboratory procedure. Refer to Section 292.600 of this manual.

NOTE: Payment will not be made for emergency room physician charges on an OB patient admitted directly from the emergency room into the hospital for delivery.

292.674 External Fetal Monitoring

~~2-1-22~~7-1-25

Procedure code must be used exclusively for external fetal monitoring when performed in a physician's office or clinic with National Place of Service code **"11"**. Physicians may bill for one unit per day of external fetal monitoring. ~~Physicians may bill for external fetal monitoring in addition to a global obstetric fee. When itemizing obstetric visits, p~~Physicians may bill for medically necessary fetal monitoring in addition to obstetric office visits.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

~~292.675 Obstetrical Care Without Delivery~~

~~2-1-22~~

~~A. Obstetrical care without delivery may be billed using procedure code, modifier **UA**, when 1 – 3 visits are provided and with no modifiers when 4 – 6 six visits are provided. Procedure code with no modifiers is payable for 7 or more visits.~~

~~**View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.**~~

~~B. These procedure codes enable physicians rendering care to the patient during the pregnancy, but not delivering the baby, to receive reimbursement for these services. Units of service billed with these procedure codes are not counted against the patient's annual physician visit benefit limit. Reimbursement for each visit includes routine sugar and protein analysis. Other lab tests may be billed separately within 12 months of the date of service.~~

~~C. Providers must enter the dates of service in the CMS-1500 claim format and the number of units being billed. One visit equals one unit of service. Providers must submit the claim within 12 months of the first date of service.~~

~~**View a CMS-1500 sample form.**~~

~~**For example:** An OB patient is seen by Dr. Smith on 1-10-05, 2-10-05, 3-10-05, 4-10-05, 5-10-05 and 6-10-05. The patient then moves and begins seeing another physician prior to the delivery. Dr. Smith may submit a claim with dates of service shown as 1-10-05 through 6-10-05 and 6 units of service entered in the appropriate field. The Arkansas Medicaid fiscal agent must receive the claim within the 12 months from the first date of service. Dr. Smith must have on file the patient's medical record that reflects each date of service being billed. Dr. Smith must bill the appropriate code: with modifier **UA** when 1 – 3~~

~~visits are provided, with no modifiers when 4 – 6 visits are provided and procedure code when 7 or more visits are provided.~~

292.6756 Risk Management for Pregnancy

~~2-1-22~~7-1-25

A physician may provide risk management services for pregnant women if he or she employs the professional staff indicated in service descriptions found in Section 247.200 of this manual. These services may be billed separately from obstetrical fees. The services in the list below are considered to be one service and are limited to 32 cumulative units. Use the modifiers when filing claims to identify the service provided.

View or print the procedure codes for Physician/Independent Lab/CRNA/Radiation Therapy Center services.

For early discharge home visits, use one of the applicable CPT procedure codes.

TOC required

218.100 RHC Encounter Benefit Limits

~~2-1-24~~7-1-25

A. Medicaid clients under the age of twenty-one (21) in the Child Health Services (EPSDT) Program do not have a rural health clinic RHC encounter benefit limit.

B. A benefit limit of sixteen (16) encounters per state fiscal year (SFY), July 1 through June 30, has been established for clients twenty-one (21) years or older. The following services are counted toward the ~~per SFY encounter~~ benefit limit:

1. Provider visits in the office, client's home, or nursing facility;
2. Certified nurse-midwife visits;
3. RHC encounters;
4. Medical services provided by a dentist;
5. Medical services provided by an optometrist;
6. Advanced practice registered nurse (APRN) services in the office, client's home, or nursing facility; and
7. Federally qualified health center (FQHC) encounters.

~~Global obstetric fees are not counted against the service encounter limit. Itemized obstetric office visits are not counted in the limit.~~Office visits coded with obstetrical visit procedure codes are not counted toward the visit limit. All other office visits count toward the established sixteen (16) visit limit.

The established benefit limit does not apply to individuals receiving Medication Assisted Treatment for Opioid Use Disorder when it is the primary diagnosis (**View ICD OUD Codes**).

Extensions of the benefit limit will be considered for services beyond the established benefit limit when documentation verifies medical necessity. Refer to Section 218.310 of this manual for procedures for obtaining extension of benefits.

5. **Physician Services (Continued)**

F. For dates of service beginning January 1, 2021, the maximum reimbursement rate for evaluation and management codes are increased by 3 percent of the 7/1/2020 fee-for-service rate for each of these codes. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of evaluation and management services. The agency's fee schedule rate was set as of January 1, 2021 and is effective for services provided on or after that date. All rates are published on the agency's website.~~, (http://medicaid.mmis.arkansas.gov/).~~

G. For dates of service beginning July 1, 2025, the maximum reimbursement rates for obstetrical care to ~~include~~ include prenatal care, delivery, and postpartum care are increased by ~~s~~seventy percent. The increase is based on an analysis of private pay rates. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website~~,~~.

Effective for dates of service on or after July 1, 2020, the immunization administration fee for influenza will be based on the 2020 Medicare flu vaccine administration fee. All other immunization administration fees will be based on Medicare's 2020 physician fee schedule for the State of Arkansas. The rate is paid to all governmental and non-governmental providers, unless otherwise specified in the state plan. All rates are published at the agency's website.~~, (http://medicaid.mmis.arkansas.gov/).~~